89 25594

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): HELEN HOLLAND
2. DATE OF DEATH: MONTH 9 DAY 14 YEAR 89
3. TIME OF DEATH: 2:35 PM
4. SOCIAL SECURITY NUMBER: 217-16-4202
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 28, 1929
8. BIRTHPLACE (State or Foreign Country): WASH. D. C.

9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE City
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 751 Druid Park Lake DR
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ ~~NO~~ Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Ernest Hutchinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille Lowe
19a. INFORMANT'S NAME (Type/Print): Mrs. Florence Ward
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2035 Penna Ave. Balto. Md.
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cem. 9-2089
20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 N. North Ave. Balto. Md. 21216

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | RESPIRATORY FAILURE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PNEUMONIA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | POLYNEUROPATHY WITH PARAPLEGIA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Terance Lamb
29c. LICENSE NUMBER: D37203
29d. DATE SIGNED (Month, Day, Year): ▶ 9-14-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TERANCE LAMB MD
31. DATE FILED (Month, Day, Year): SEP 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-1S Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25595

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

12

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William H. Hart | | | 2. DATE OF DEATH: MONTH 9 DAY 15 YEAR 89 | 3. TIME OF DEATH: 6:36 PM |
| 4. SOCIAL SECURITY NUMBER: 215-05-6858 | 5. SEX: ~~X~~ 1 M 2 F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 9, 1898 | 8. BIRTHPLACE (State or Foreign Country): York, Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): Fallston General Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Fallston MD | 9c. COUNTY OF DEATH: Harford | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Fallston | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1301 Mill Creek Rd. | | 10f. ZIP CODE: 21047 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ~~X~~ NO IF YES, GIVE WAR OR DATES ~~XX~~ | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer Mgr. | 16b. KIND OF BUSINESS/INDUSTRY: McCormick & Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Harry C. Hart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne E. Streett | |
| 19a. INFORMANT'S NAME (Type/Print): Nellie C. Hart | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1301 Mill Creek Rd. Fallston, Md. 21047 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Slate Ridge Cemetery | 20c. LOCATION — City or Town, State: Delta, Pa. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn | | 22. NAME AND ADDRESS OF FACILITY: E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiogenic Shock + Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Ischemic Heart Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and menner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |
|---|---|---|
| | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Randall

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 20 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

9 166 64 15 JHH
JONES, MARY F
8/06 F

89 25596

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY F. K. JONES | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 16, 1989 | 3. TIME OF DEATH: 9:50 A M |
| 4. SOCIAL SECURITY NUMBER: 212-07-4816 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8-22-02 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1716 LLEWELYN AVENUE | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): LEW ROBINSON SR. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 126 JUNIPER LANE/BALTIMORE, MD 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY | 20c. LOCATION — City or Town, State: CATONSVILLE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Vanessa Davis | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Intracranial hemorrhage | 5days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | cerebral vascular accident | 8days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | hypertension | 20years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jacqueline M Junkins | 29c. LICENSE NUMBER: C8293 | 29d. DATE SIGNED (Month, Day, Year): 9/16/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jacqueline M Junkins | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Unknow 89-167

89 25597

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Lee Johnson JR.
2. DATE OF DEATH (Month, Day, Year): 9-13-89
3. TIME OF DEATH: 1:45a M
4. SOCIAL SECURITY NUMBER: 219-98-1967
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 23 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/27/66
8. BIRTHPLACE (State or Foreign Country): Baltimore, Md.
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4012 Oswego Ct.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elamantary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Unemployed
17. FATHER'S NAME (First, Middle, Last): Charles Lee Johnson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty D. Miles
19a. INFORMANT'S NAME (Type/Print): Betty D. Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4012 Oswego Ct. Balto. Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion Cemetery
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edna Adams Jones
22. NAME AND ADDRESS OF FACILITY: Marshall W. Jones, Jr. F.H. P.A. 401 Edmondson Ave. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gunshot Wounds
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 9-13-89
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: Subject Shot
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2200 Blk Ellamont st. Balto. Md.
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 9-13-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St. Baltimore, Md. 21201
31. DATE FILED (Month, Day, Year): SEP 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25598

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gregory B. Johnson | | 2. DATE OF DEATH (Month, Day, Year): 9-15-89 | 3. TIME OF DEATH: 9:23PM M |
| 4. SOCIAL SECURITY NUMBER: 218-92-2159 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 24 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 2-18-65 |
| 8. BIRTHPLACE (State or Foreign Country): Balto. Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1915 E. 30th Street | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Alfred Johnson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Adams | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Marie Johnson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1915 E. 30th St Balto. Md. 21218 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cem | 20c. LOCATION — City or Town, State: Baltimore Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 N. North Ave. Balto. Md. 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Bronchial asthma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-16-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. | 111 Penn Street, Baltimore, MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall | |

DNMN-16 Rev 1/89

JONES, WILLIAM E. ICH2
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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William EDWIN JONES JR. | | 2. DATE OF DEATH (Month, Day, Year): September 17, 1989 | 3. TIME OF DEATH: 11:30 p M |
| 4. SOCIAL SECURITY NUMBER: 218-14-2847 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-20-1912 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6721 University Drive | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Millright | 16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last): W. Edwin Jones, Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Fitzell | | |
| 19a. INFORMANT'S NAME (Type/Print): Phylis D. Wagenfuehr | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6721 University Drive Baltimore, Maryland 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Park | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Susan's Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Asystole | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiogenic shock | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Pulmonary edema | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter White, Jr M.D. | 29c. LICENSE NUMBER: # 36775 | 29d. DATE SIGNED (Month, Day, Year): 9-17-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter White, Jr., M.D. | 9000 Franklin Square Drive 21237 | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BEATRICE L. KNAUB | | | 2. DATE OF DEATH (Month, Day, Year): 9/18/89 | 3. TIME OF DEATH: 5:30 P M |
| 4. SOCIAL SECURITY NUMBER: 705-10-9254 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/23/11 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2316 Cloville Ave. | | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Robert L. Badart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude L. Scott | |
| 19a. INFORMANT'S NAME (Type/Print): Edward L. Knaub | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1015 Stormont Circle Baltimore, Md. 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Parkville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christopher N. Miles | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SHOCK
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. UPPER GASTRO INTESTINAL BLEEDING
DUE TO (OR AS A CONSEQUENCE OF):
c. CARCINOMA OF THE BLADDER. METASTATIC.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: RESIDENT. MEDICINE | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 09/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ELMER E. HUERTA M.D. 900 S. CATON AV. BALTIMORE MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use at the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM KUHN | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 18, 1989 | 3. TIME OF DEATH: 6:33 P. M |
| 4. SOCIAL SECURITY NUMBER: 082-01-0921 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/2/08 | 8. BIRTHPLACE (State or Foreign Country): GERMANY |
| 9a. FACILITY NAME (If not institution, give street and number): 10328 GELDING DRIVE, APT. A #21093 | | 9b. CITY, TOWN OR LOCATION OF DEATH: COCKEYSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMOR E | 10c. CITY, TOWN OR LOCATION: COCKEYSVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 10328 GELDING DRIVE, APT. A | | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | 16b. KIND OF BUSINESS/INDUSTRY: MD CUP CORP. | |
| 17. FATHER'S NAME (First, Middle, Last): KUHN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): | |
| 19a. INFORMANT'S NAME (Type/Print): STEVEN SILBERG, ATTY. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 S. CALVERT ST., SUITE 300 BALTO., MD 21202 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. aortic stenosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CHF | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic obstructive dis leg

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [✓] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harry S. Gemtel MD | 29c. LICENSE NUMBER: D0 1976 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9.1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Harry S. Gemtel MD - 3126 Balto. Nat. pike - Balto, md 21229 | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie M. Koetting | | | 2. DATE OF DEATH (Month, Day, Year): 9-15-89 | 3. TIME OF DEATH: 1:05PM M |
| 4. SOCIAL SECURITY NUMBER: 213-34-5809 | 5. SEX: 1 ☐ M 2 XX F | 6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-6-1912 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 70 Helmsman Court | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore County | 9c. COUNTY OF DEATH: Baltimore County | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 70 Helmsman Court | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking | |
| 17. FATHER'S NAME (First, Middle, Last): William Homberg | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Johnson | | |
| 19a. INFORMANT'S NAME (Type/Print): William Koetting, Jr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2404 Bauernschmidt Drive Balto., Md. 21221 | | |
| 20a. METHOD OF DISPOSITION: X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lassahn Funeral Home Inc | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 XX YES 2 ☐ NO HEAD ONLY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-16-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

89 25603

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Benjamin H. Lewis, Jr | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 18, 1989 | 3. TIME OF DEATH: 12:10p M |
| 4. SOCIAL SECURITY NUMBER: 215-22-4335 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-10-1928 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2305 Ocala Avenue | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Benjamin H. Lewis, Sr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Geneva Williams | |
| 19a. INFORMANT'S NAME (Type/Print): Nancy L. Lewis | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2305 Ocala Avenue Balto, Md 21215 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park | 20c. LOCATION — City or Town, State: Catonsville, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Irene A. Thompson | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular Tachycardia, Asystole | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertension, Cerebrovascular accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Smoker and chronic alcohol abuse. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bhajan S. Dara, M.D. | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bhajanial S. Dara, M.D. | c/o Maryland General Hospital | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

89 25604

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE M. LAUBACH | | | | 2. DATE OF DEATH (Month, Day, Year): 9 / 15 / 89 | 3. TIME OF DEATH: 11:45 P M |
| 4. SOCIAL SECURITY NUMBER: 220-12-7279 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7/28/10 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): FQH 200 Milton Ave. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Fallston, MD. | | 9c. COUNTY OF DEATH: Harford. |

**RESIDENCE OF DECEDENT**

| | | | | |
|---|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Balt | 10c. CITY, TOWN OR LOCATION: glen Arm | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 4413 Langtry Drive | | 10f. ZIP CODE: 21057 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Yrs. / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House wife | 16b. KIND OF BUSINESS/INDUSTRY: Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Fred C. Wiegand | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha E. Bohlen | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Berta M. Costello | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4413 Langtry Dr. Glen arm, Md, 21057 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Zion Luth. Ch. Cemetery | 20c. LOCATION — City or Town, State: Stemmers Run, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn | | 22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. "Sudden death" - cardiac arrythmia ? | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Tubulo villous Adenoca Rectum. | 16 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Rheu. Aortic valve dis. & CHF | > 25 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Alzheimer's Disease. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: B. PAREKH M.D. | 29c. LICENSE NUMBER: D.18424 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. PAREKH M.D. 1908 HARFORD RD, FALLSTON M.D. 21047.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall |

DHMH-16 Rev 1/89

89 25605

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LILLI ANN MCCLUSKEY | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 17, 1989 | 3. TIME OF DEATH: 12:50p M |
| 4. SOCIAL SECURITY NUMBER: 434-42-4844 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/25/32 |
| 8. BIRTHPLACE (State or Foreign Country): Louisianna | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 109 Woodlin Avenue | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Sullie Langley | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anise Savoy | | |
| 19a. INFORMANT'S NAME (Type/Print): John J. McCluskey | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Woodlin Ave. Baltimore, Maryland 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Augustine Catholic Cem. | 20c. LOCATION — City or Town, State: Bazil, Louisanna | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie L. Shannon | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lymphoma (Diffuse Hysiocytic) DUE TO (OR AS A CONSEQUENCE OF): | 9 yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Erythema Multiforme

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NA; 28b. TIME OF INJURY: M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO; 28d. DESCRIBE HOW INJURY OCCURED: NA | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Brad Sherrill M.D. | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Brad Sherrill Medical Resident Johns Hopkins Hospital | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: | |

DHMH-16 Rev 1/89

89 25606

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE OREN MARSHALL

2. DATE OF DEATH (Month, Day, Year): 9 18 89

3. TIME OF DEATH: 9:14 P.M.

4. SOCIAL SECURITY NUMBER: 414-64-0124

5. SEX: 1 ☑ M 2 ☐ F

6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): 7/17/04

8. BIRTHPLACE (State or Foreign Country): Tennessee

9a. FACILITY NAME (If not institution, give street and number): ST AGNES HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Arbutus

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 1135 Regina Drive

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): Bachelors Degree

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher

16b. KIND OF BUSINESS/INDUSTRY: Baltimore Ccounty

17. FATHER'S NAME (First, Middle, Last): John C. Marshall

16. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Belle McCollum

19a. INFORMANT'S NAME (Type/Print): George A. Etter

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1135 Regina Drive Baltimore, Md. 21227

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Hoff

22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc.
4107 Wilkens Ave. Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RECURRENT PULMONARY EDEMA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHRONIC RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d. Arteriosclerotic Cardio Vaswlar Disease

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: RESIDENT, MEDICINE

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year) ▶ 09/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ELMER E. HUERTA M.D. 900 S. Caton Av. Baltimore, MD 21229

31. DATE FILED (Month, Day, Year): SEP 20 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Trandell

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Olga F. Mainolfi | | 2. DATE OF DEATH (Month, Day, Year): September 16, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 214-82-6998 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 25, 1914 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 3908 Wilkinson Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace | 9c. COUNTY OF DEATH: Harford | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Havre de Grace | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3908 Wilkinson Road | 10f. ZIP CODE: 21078 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): John J. Jelinek | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Antonia Dvorak | |
| 19a. INFORMANT'S NAME (Type/Print): E. Patrick McDonough | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1212 Argonne Drive Baltimore, Md. 21218 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Gladden | 22. NAME AND ADDRESS OF FACILITY: Leonard J. RuckInc. 5305 Harford Rd. 21214 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CORONARY ARTERY OCCLUSION

DUE TO (OR AS A CONSEQUENCE OF):
c. HYPERTENSIVE CARDIOVASCULAR DISEASE.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PULMONARY EMPHYSEMA

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph D. Notarangelo M.D. | 29c. LICENSE NUMBER: D0 7316 | 29d. DATE SIGNED (Month, Day, Year): ▶ SEPT-18-1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Notarangelo Mercy Hospital Baltimore, Maryland | | |
| 31. DATE FILED (Month, Day, Year): SEP 19 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached by the funeral director, and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 25608

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVELYN Evelyn S. MURRAY Murray | 2. DATE OF DEATH (Month, Day, Year): SEPT 17 1989 | 3. TIME OF DEATH: 708 P. M |
| 4. SOCIAL SECURITY NUMBER: 173-12-9821 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-24-21 |
| 8. BIRTHPLACE (State or Foreign Country): Penna. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | 9c. COUNTY OF DEATH: Balto. | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7304 Conley St. | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production - Ret. | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Michael Sharik | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Valiska | | |
| 19a. INFORMANT'S NAME (Type/Print): Rowean E. Eckert | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9929 Harford Rd. Baltimore, Md. 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery 9/20/89 | 20c. LOCATION — City or Town, State: Baltimore Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Milton J. Knight Jr. Milton J. Knight Jr | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GANGRENE BOWEL — 12 HRS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. RENAL FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

c. PERIPHERAL VASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESECTION ABDOMINAL AORTIC AND ILIAC ARTERY ANEURYSMS.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D16381

29d. DATE SIGNED (Month, Day, Year): ▶ 9/17/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] SUITE 200 BANNER BLDG, 300 S. HANOVER ST BALT 21230

31. DATE FILED (Month, Day, Year): SEP 20 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25609

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert C Marshall
2. DATE OF DEATH — MONTH: 9 DAY: 10 YEAR: 89
3. TIME OF DEATH: 247 A M
4. SOCIAL SECURITY NUMBER: 220-66-0809
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 33 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/1/56
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): University of Maryland
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 556 Robert St
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired): Disabled
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Harris Lee Marshall Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine NMI Marshall
19a. INFORMANT'S NAME (Type/Print): Medical record
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cem.
20c. LOCATION — City or Town, State: Catonsville MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles Braun
22. NAME AND ADDRESS OF FACILITY: P.O. Box 4433, Braun-Thompson, Balto., MD 21223

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | overwhelming Sepsis | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): b. | pneumococcal pneumonia | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | alcoholism | YRS |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: severe malnutrition

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Pamela Amelung
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 9/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Pamela J. Amelung 22 S. Greene St Baltimore 21201
31. DATE FILED (Month, Day, Year): SEP 20 1989
32. REGISTRAR'S SIGNATURE: Gitta Davidson-Randall

DHMH-18 Rev 1/89

89 25609

89 25610

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PAUL W. MARSHALL | | | 2. DATE OF DEATH (Month, Day, Year): 9 14 89 | 3. TIME OF DEATH: 10:20 PM |
| 4. SOCIAL SECURITY NUMBER: 214-16-4461 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/6/14 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): SALISBURY NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MD. | | 9c. COUNTY OF DEATH: WICOMICO COUNTY |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Somerset | 10c. CITY, TOWN OR LOCATION: Tylerton, MD | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: RR Box 61 | | 10f. ZIP CODE: 21866 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 7; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman | | 16b. KIND OF BUSINESS/INDUSTRY: Seafood |
| 17. FATHER'S NAME (First, Middle, Last): John C. Marshall | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Bradshaw | | |
| 19a. INFORMANT'S NAME (Type/Print): Johnnie C. Marshall | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 224 - Tylerton, MD 21866 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Tylerton Church Cemetery | | 20c. LOCATION — City or Town, State: Tylerton, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert H. Bradshaw Jr | | 22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerotic cardiovascular disease
Diabetes
Peripheral vascular disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D25219 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles D. Stegman, M.D. - Mt. Vernon Rd. - Princess Anne, MD 21853 | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

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Items:16a,16b per FH G-655

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RALPH MIELE | | | 2. DATE OF DEATH (Month, Day, Year): 09 16 89 | 3. TIME OF DEATH: 08:54 PM |
| 4. SOCIAL SECURITY NUMBER: 008 03 1380 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 04 15 08 | 8. BIRTHPLACE (State or Foreign Country): VErmont |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6102 Eastern PArkway | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ~~SElfEmployed~~ Machinist | 16b. KIND OF BUSINESS/INDUSTRY: Fellows Gear Shaper ~~LUmber Business~~ | |
| 17. FATHER'S NAME (First, Middle, Last): Guy Miele | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FRances Russo | |
| 19a. INFORMANT'S NAME (Type/Print): Mary C. Beauchamp | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6102 EAstern PArkway BAltimore,MD.=21206 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount CEmetery | 20c. LOCATION — City or Town, State: Baltimore,MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 BElair Road-Baltimore,Md.-21206 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Dilated heart

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [✓] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [✓] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Beth R Schwartz MD | 29c. LICENSE NUMBER: D38352 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Beth R Schwartz MD Greater Baltimore Medical Center | | |
| 31. DATE FILED (Month, Day, Year): 9/17/~~SEP~~ 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William · Nelson MASON | | | | 2. DATE OF DEATH (Month, Day, Year): 9 - 14 - 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 411-28-0131 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-22-25 | 8. BIRTHPLACE (State or Foreign Country): TENNESSEE |
| 9a. FACILITY NAME (If not institution, give street and number): 3700 Lochearn Dr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3700 Lochearn Drive | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Nelse MASON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Willa MASON | |
| 19a. INFORMANT'S NAME (Type/Print): Leronia A Josey-Mason | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3700 Lochearn Dr. Balto, MD. 21207 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet Cemetery | 20c. LOCATION — City or Town, State: Owings Mills, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown | | 22. NAME AND ADDRESS OF FACILITY: 1206 W. North Ave Wm. C. Brown Community Funeral Home | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | (1) a. END STAGE CHRONIC OBSTRUCTIVE LUNG | |
| | DUE TO (OR AS A CONSEQUENCE OF): b. Dyspnea. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | (2) c. Probable Respiratory failure and or | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Cardiac arrythmia due to one. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetic Mellitus.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R-M. Shah. M-D. | 29c. LICENSE NUMBER: D19668. | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-14-89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R-M. SHAH. M-D. 10706 REISTERTOWN RD. OWINGS MILL, MD. 21117. | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Myrtle Mae Nicholson
2. DATE OF DEATH (Month, Day, Year): 9-15-89
3. TIME OF DEATH: 1:01 AM
4. SOCIAL SECURITY NUMBER: 213-36-0353
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS.
   IF UNDER 1 YEAR: MONTHS / DAYS
   IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-28-10
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Inns of Evergreen
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1213 N. Chester St
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
    IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Jeremiah Nicholson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie
19a. INFORMANT'S NAME (Type/Print): Mrs. Madelon Bradford
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 922 N. Fulton Ave. Balto. Md. 21217
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Buss
22. NAME AND ADDRESS OF FACILITY: Joseph L. Buss Funeral Home 2222 W. North Ave Balto. Md 21216

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | URINARY TRACT INFECTION | UNK |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | CVA- | YRS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | HYPERTENSION | YRS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | SEIZURES | YRS |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
~~BF~~

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K.M. Zonies MD
29c. LICENSE NUMBER: D20333
29d. DATE SIGNED (Month, Day, Year): ▶ 9/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. M. ZONIES MD
31. DATE FILED (Month, Day, Year): SEP 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25614

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jannie B. Neal | | | 2. DATE OF DEATH: MONTH 9 DAY 15 YEAR 89 | 3. TIME OF DEATH: 1135 PM |
| 4. SOCIAL SECURITY NUMBER: 220-14-5321 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-13-1903 | 8. BIRTHPLACE (State or Foreign Country): N.C |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4816 Norwood Ave | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| | | | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Thomas Grager | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Dryer |
| 19a. INFORMANT'S NAME (Type/Print): Audretta Smith | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4816 Norwood Ave Balto, Md 21207 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): King Mem Park | 20c. LOCATION — City or Town, State: Randallstown, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Ebron | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic coronary vascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congestive heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Chronic renal failure | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic & Mitral Valve disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Blake Kutsche MD | 29c. LICENSE NUMBER: D 35788 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
B. KUTSCHE LIBERTY MEDICAL CENTER BALTIMORE, MD 21215

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERTHA A PRESTLEY | | | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 16, 1989 | 3. TIME OF DEATH: 11:37P M |
| 4. SOCIAL SECURITY NUMBER: 219-10-8324 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-18-1905 | 8. BIRTHPLACE (State or Foreign Country): SC |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1617 St. Stephen Street | | 10f. ZIP CODE: 21216 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Green Mills | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Fair |
| 19a. INFORMANT'S NAME (Type/Print): Clarence Mills | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1719 Edmondson Avenue, Balto., MD 21223 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National Cemetery | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 2222-26 West North Ave., Balto., MD 21216 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 1 day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy
Peptic Ulcer Disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year) ▶ |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy J. Kamp MD | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

15 OCT 75 A
PRESTLEY, BERTHA A
015 30 03/18/05

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Samuel ~~Dublin~~ PUDLIN JR. | | | 2. DATE OF DEATH (Month, Day, Year): 9 - 15 - 89 | | 3. TIME OF DEATH: 1555 M |
| 4. SOCIAL SECURITY NUMBER: 219-01-~~6892~~ 7558 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3 - 14 - 19 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): BALTO COUNTY GENERAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTO | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1750 EASTERN AVE. | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 TH; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ASSEMBLY | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL PUDLIN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHERINE BRUCKHEISNER | |
| 19a. INFORMANT'S NAME (Type/Print): MADELINA YARTZ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1750 EASTERN AVE BALTO. MD. 21231 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT | 20c. LOCATION — City or Town, State: BALTO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: EDWARD J. WEBER F.H. 401 S. CHESTER ST. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D11171 | ▶ 9.15.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5550 BALTIMORE NATIONAL PK - BALTO 21228 MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 20 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert (Robertson) Robinson | | 2. DATE OF DEATH: MONTH 9 DAY 16 YEAR 89 | 3. TIME OF DEATH: 8:30pm M |
| 4. SOCIAL SECURITY NUMBER: 246 10 7048 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS ... DAYS ... IF UNDER 24 HRS.: HOURS ... MIN. ... | 7. DATE OF BIRTH (Month, Day, Year): 5/9/14 |
| 8. BIRTHPLACE (State or Foreign Country): S.C | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimoe VA (Loughraven) Loch Raven | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2101 Ashburton | 10f. ZIP CODE: 21216 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) ... College (1-4 or 5+) ... | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Tom R. Robinson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Chirty Harril | |
| 19a. INFORMANT'S NAME (Type/Print): Pernice Smothers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3410 Woodland Ave | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ... | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest | 20c. LOCATION — City or Town, State: Owings Mills, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome A. Thompson | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiovasaular collapse | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. septicaemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. urosepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Catherine Jane Haslam MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 16th Sept 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): catherine Jane Haslam — 2C1 Loughraan VA | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HILDA ROBINSON
2. DATE OF DEATH: MONTH 9 DAY 18 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-25-5669
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/11/1925
8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): POPLAR MANOR NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 313 Poplar Street
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify, Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: none
17. FATHER'S NAME (First, Middle, Last): unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Blackwell
19a. INFORMANT'S NAME (Type/Print): William Bowling
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 McMechen St Baltimore MD
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT Zion
20c. LOCATION — City or Town, State: Baltimore MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Matthias L McClennon
22. NAME AND ADDRESS OF FACILITY: 2302 W North Ave 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHF
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marc Cimm MD
29c. LICENSE NUMBER: D23760
29d. DATE SIGNED (Month, Day, Year): 9/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARC D CIMM 9141 BALT NAT RICE EL MD 21043
31. DATE FILED (Month, Day, Year): SEP 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician; Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WALTER A. RICHARDSON | | | 2. DATE OF DEATH (Month, Day, Year): 9-17-89 | 3. TIME OF DEATH: 12:05 AM |
| 4. SOCIAL SECURITY NUMBER: 116-12-7742A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-8-07 | 8. BIRTHPLACE (State or Foreign Country): Texas |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secours | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1408 W. Baltimore St. | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic | 16b. KIND OF BUSINESS/INDUSTRY: Unknown | |
| 17. FATHER'S NAME (First, Middle, Last): Walter Richardson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma | |
| 19a. INFORMANT'S NAME (Type/Print): Jessie T. Richardson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1403 Baltimore St., Balto., MD., 21223 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Veterans Cemetery | 20c. LOCATION — City or Town, State: Crownsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charlene Braun | | 22. NAME AND ADDRESS OF FACILITY: Brown & Thompson Funeral Home P.O. Box 4433 Balto, 21223 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adult Respiratory Distress Syndrome | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ca of Prostate | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Lung Disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 25f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D16263 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN A. BELTRAN 1940 W. BALTIMORE ST, BALT. Md 21223

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward Roundtree | | | | 2. DATE OF DEATH (Month, Day, Year): 09 16 89 | 3. TIME OF DEATH: 0550 A M |
| 4. SOCIAL SECURITY NUMBER: 216-32-5231 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 52 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 03-10-37 | 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: NONE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: NONE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3932 REXMERE RD. | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: NEGROID |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): none | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): steelworker | 16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL | |
| 17. FATHER'S NAME (First, Middle, Last): SAMMY LEE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EARLENE ROUNDTREE | |
| 19a. INFORMANT'S NAME (Type/Print): GERALDINE ROUNDTREE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3932 REXMERE RD, BALTO, MD. 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY | 20c. LOCATION — City or Town, State: MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs Sr | 22. NAME AND ADDRESS OF FACILITY: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASPIRATION of BLOOD | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MASSIVE UPPER GI BLEEDING | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. ESOPAGEAL CANCER | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATN (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATN: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Judith Thomas MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Judith Thomas MD 202 E University Pkwy Balto MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25621

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John David St. Clair | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 18 / 89 | 3. TIME OF DEATH: 9:30 p M |
| 4. SOCIAL SECURITY NUMBER: 207-24-0713 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 58 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4/2/31 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 8a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Woodlawn | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7117 Campfield Road | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Purchasing | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse |
| 17. FATHER'S NAME (First, Middle, Last): Milford A. St. Clair | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Tulowesky | |
| 19a. INFORMANT'S NAME (Type/Print): Joan Tilley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd5 Box 452 Johnstown, Pa. 15905 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc. | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond Peterson | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St., Baltimore, MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE | |

OHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-cremation permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Stella N. Sabalauskas | | | 2. DATE OF DEATH: MONTH 9 DAY 18 YEAR 89 | 3. TIME OF DEATH: 8:58 PM |
| 4. SOCIAL SECURITY NUMBER: 217-01-6239 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. / IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/13/18 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 128 Westowne Place | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 128 Westowne Place | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc.: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown College (1-4 or 8+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): sales | | 16b. KIND OF BUSINESS/INDUSTRY: retail |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Navagrockis | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Stella Motiecius | | |
| 19a. INFORMANT'S NAME (Type/Print): J. Michael Lehane | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 744 Equitable Bldg. Balto. MD 21202 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer | | 20c. LOCATION — City or Town, State: Balto. MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter Ashton Draw 4 | | 22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Home PA 736 Edmondson Ave. Balto. MD 21228 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC ENDOMETRIAL CARCINOMA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D19419 | ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DIANA H. GRIFFITH 900 Caton Ave. Balt. Md. 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 20 1989 | John Davidson-Randall |

DHMH-16 Rev 1/89

89 25625

89 25623

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gustav Lorenz STAEHLING | | | 2. DATE OF DEATH (Month, Day, Year): September 16, 89 | 3. TIME OF DEATH: 1:10 PM |
| 4. SOCIAL SECURITY NUMBER: 482-03-9864 | 5. SEX: X 1 M 2 F | 6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4-26-1910 | 8. BIRTHPLACE (State or Foreign Country): Iowa |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Fullerton | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 4223 Cardwell Avenue | | 10f. ZIP CODE: 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4 or 5+): 5 yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrical Engineer | | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse |
| 17. FATHER'S NAME (First, Middle, Last): J. Otto Staehling | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Marie Ide | | |
| 19a. INFORMANT'S NAME (Type/Print): Esther Staehling | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4223 Cardwell Avenue Balto., Md. 21236 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lessner Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Intracranial (subarachnoid) hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Status Post Cerebral vascular accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Naeem Gauhar MD | D18326 | ▶ 9/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Naeem Gauhar 9000 Franklin Square Drive, Baltimore 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 20 1989 | John Davidson-Randall |

DHMH-18 Rev 1/89

89 25624

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

4

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY SHAFER | | | 2. DATE OF DEATH (Month, Day, Year): Sept 16 1989 | 3. TIME OF DEATH: 1:35 A M |
| 4. SOCIAL SECURITY NUMBER: 215-01-4211 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-13-1893 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5 Walkway Court | 10f. ZIP CODE: 2120 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory Worker | 16b. KIND OF BUSINESS/INDUSTRY: Can Company | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Shandara | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Bersick | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Bradford | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Walkway Court Baltimore, Maryland 21220 | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lessner Funeral Home Inc. | | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Congestive heart failure | 10 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Sepsis | ? 3 Days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul A. Eder MD | 29c. LICENSE NUMBER: D38282 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul A. Eder MD, Francis Scott Key Med Ctr, Eastern Ave, Balt. MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall |

DHMH-16 Rev 1/89

89 25621

Item#7 Film#659 01/17/90 da

89 25625

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Scott Frances Ann | | | | 2. DATE OF DEATH MONTH 9 DAY 15 YEAR 89 | 3. TIME OF DEATH 9:15 AM |
| 4. SOCIAL SECURITY NUMBER: 234-46-8265 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | APRIL 28, 1929 ~~9-15-1989~~ | 8. BIRTHPLACE (State or Foreign Country): W. Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frederick | | 9c. COUNTY OF DEATH: Frederick |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: W. Va. | 10b. COUNTY: Berkeley | 10c. CITY, TOWN OR LOCATION: Martinsburg | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 118 North High Street | | 10f. ZIP CODE: 25401 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): senior citizen rep. | 16b. KIND OF BUSINESS/INDUSTRY: service | |
| 17. FATHER'S NAME (First, Middle, Last): Nelson W. Creamer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanor Washington | |
| 19a. INFORMANT'S NAME (Type/Print): Janice L. Williams | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 42 E. 4th Street Frederick, Md. 21701 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pleasant View Memory Gardens | 20c. LOCATION — City or Town, State: Martinsburg, W. Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Alva D. Linder | 22. NAME AND ADDRESS OF FACILITY: Rosedale Funeral Chapel 2060 Rosedale Rd Mtsbg, W. Va. 25401 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ventricular flutter | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. end stage ischemic cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29e. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John A. Vitarello M.D. | 29c. LICENSE NUMBER: D27544 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Gebe Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25625

B

Items:23 thru 28f per ME G-656
10-18-89 cm

89 25626

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in obtaining burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bernard Strickland | | | 2. DATE OF DEATH Month/Day/Year: 9-14-89 | 3. TIME OF DEATH: 3:47pm M |
| 4. SOCIAL SECURITY NUMBER: 213-46-0294 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 42 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-31-46 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 849 McKim CT. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore,City | | 9c. COUNTY OF DEATH: NONE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: NONE | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 849 MC KIM CT. | | 10f. ZIP CODE: 212 | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: NEGROID |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4 or 5+): NONE | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED | 16b. KIND OF BUSINESS/INDUSTRY: NONE |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM STRICKLAND JR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): THELMA |
| 19a. INFORMANT'S NAME (Type/Print): SUSAN R. STRICKLAND | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1707 LAMONT AVENUE BALTO,MD. 21202 |
| 20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT ZION CEMETERY | 20c. LOCATION — City or Town, State: MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs Jr. | 22. NAME AND ADDRESS OF FACILITY: CALVIN B. SCRUGGS FUNERAL HOME 1412E. PRESTON ST. BALTO. MD. 21213 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Narcotic intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-5-89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 849 McKim Street Baltimore, Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Baltimore,MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

89 25627

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the [illegible] permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Regina H. Taylor | | 2. DATE OF DEATH (Month, Day, Year): Sept. 16, 1989 | 3. TIME OF DEATH: 1:20p M |
| 4. SOCIAL SECURITY NUMBER: 212-03-3198 A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-12-1905 |
| 8. BIRTHPLACE (State or Foreign Country): N. C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2238 Madison Avenue | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Elevator operator | 16b. KIND OF BUSINESS/INDUSTRY: Ham erger Clothing Store | |
| 17. FATHER'S NAME (First, Middle, Last): George Harrington | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dillia Wadsworth | | |
| 19a. INFORMANT'S NAME (Type/Print): Samuel Taylor | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2238 Madison Avenue Balto, Md 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park | 20c. LOCATION — City or Town, State: Arbutus, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerome A. Thompson | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Massive Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension/Hypotension; Diabetes Mellitus

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Nuhad Kulayat, M.D. | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. Kulayat c/o Maryland General Hospital | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-t8 Rev t/89

89 25627

89 25628

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Irene M. ULRICH | | | 2. DATE OF DEATH: MONTH 9 DAY 15 YEAR 89 | 3. TIME OF DEATH: 11:12 P M |
| 4. SOCIAL SECURITY NUMBER: 388-36-8896 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/20/39 | 8. BIRTHPLACE (State or Foreign Country): WISCONSIN |
| 9a. FACILITY NAME (If not institution, give street and number): Homewood Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto City | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Balto | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 909 N. Calvert St | | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY? US | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas KRNOWSKI | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agatha KRNOWSKI | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles F. Ulrich | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 909 N. Calvert St. 21202 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other): Metro Cemetery | 20c. LOCATION — City or Town, State: Balto. Co. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Geoffrey Miller | | 22. NAME AND ADDRESS OF FACILITY: Jeff Miller F/H | 1639 N. Broadway Balto. Md. 21213 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D28266 | ▶ 9.15.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Homewood South Hospital Center, Balto., MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 18 1989 | Sylvia Davidson-Randall |

DHMH-16 Rev 1/89

89 25629

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

24

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HOWARD LEE WATSON | | | | | 2. DATE OF DEATH: MONTH 9 DAY 17 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-30-3126 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-15-32 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Ctr. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore County | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 11 Gilland Court | | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 8+): 4 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plant Manager | 16b. KIND OF BUSINESS/INDUSTRY: Maryland Cup Corporation | |
| 17. FATHER'S NAME (First, Middle, Last): George Watson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Norma E. Rhodes | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy B. Watson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 G illand Court Baltimore, Maryland 21236 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lessels Funeral Home Inc. | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Renal Carcinoma | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles A. Padgett MD | D15546 | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles A. Padgett (532-3990) Good Sam. Prof. Bldg. Suite 107 (1st Floor)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 20 1989 | Gisha Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25630

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Florence McAllister Murchison Vincent / FLORENCE M Vincent | | | 2. DATE OF DEATH MONTH 9 DAY 19 YEAR 89 | 3. TIME OF DEATH 3 45 A M | | |
| 4. SOCIAL SECURITY NUMBER 216-32-7019 | 5. SEX 1 M 2 XF | 6. AGE (In yrs. last birthday) 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) Nov. 30, 1905 | 8. BIRTHPLACE (State or Foreign Country) South Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, MD | 9c. COUNTY OF DEATH Baltimore County | | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE Maryland | 10b. COUNTY ---------- | | 10c. CITY, TOWN OR LOCATION Baltimore City | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| 10e. STREET AND NUMBER 127 W. Lanvale Street | | | 10f. ZIP CODE 21217 | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) 4 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Placement Director | 16b. KIND OF BUSINESS/INDUSTRY Loyola College/Education | | |
| 17. FATHER'S NAME (First, Middle, Last) John D. Murchison | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Stackhouse | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Carroll Vincent | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Ridgely Road, Lutherville, Maryland 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens | 20c. LOCATION — City or Town, State Timonium, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson / Martin D. Lawson | | | 22. NAME AND ADDRESS OF FACILITY Dulaney Valley Home of Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD 21093 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma - primary unknown (presumed Adrenal) | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice | | |
| 27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Carla S. Alexander M.D. | D27087 | ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 20 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ottavious E Vinciguerra
2. DATE OF DEATH (Month, Day, Year): 9 18 89
3. TIME OF DEATH: [illegible]0206 M
4. SOCIAL SECURITY NUMBER: 216 24 3710
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07-01-28
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTO
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1124 HARWAL RD
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: KOREAN
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elemantery/Secondary (0-12): 10 GR — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN
16b. KIND OF BUSINESS/INDUSTRY: SEARS
17. FATHER'S NAME (First, Middle, Last): THOMAS VINCIGUERRA
16. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH FEBO
19a. INFORMANT'S NAME (Type/Print): JEAN VINCIGUERRA
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1124 HARWAL RD BALTO MD 21207
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CRESTLAWN
20c. LOCATION — City or Town, State: MARRIOTTSVILLE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward J Weber
22. NAME AND ADDRESS OF FACILITY: EDWARD J WEBER 5311 EDMONDSON AVE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Vent. Fibrillation | 1m |
| DUE TO (OR AS A CONSEQUENCE OF): | Myocardial Ischemia | 2h |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | CABG, ASCVD | 25y |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond Dix
29c. LICENSE NUMBER: D050
29d. DATE SIGNED (Month, Day, Year): 9/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raymond Dix BALTO
31. DATE FILED (Month, Day, Year): 9 SEP 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ESTHER A. WROTEN | | | 2. DATE OF DEATH (Month, Day, Year): 09 18 89 | 3. TIME OF DEATH: 0125 PM M |
| 4. SOCIAL SECURITY NUMBER: 214-26-9330 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/8/14 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: A.A. County | 10c. CITY, TOWN OR LOCATION: Ferndale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 100 Second Ave. South | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: — |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John Allen | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Cooper |
| 19a. INFORMANT'S NAME (Type/Print): Edgar J. Wroten | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 2nd Ave. S. Ferndale Md. 21061 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cem. | 20c. LOCATION — City or Town, State: 7350 Hockley Ave Dundalk Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Hurley Dodson | 22. NAME AND ADDRESS OF FACILITY: Charles F. Flamm Funeral Home Inc. 501 E 2nd Ave. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis — | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Diabetes mellitus complicated | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Severe Bedsores | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None — ASHD — COPD

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jorge B Ramirez MD | 29c. LICENSE NUMBER: D09596 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): JORGE B. RAMIREZ, M.D. 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA BELL WOODARD
2. DATE OF DEATH (Month, Day, Year): 9-14-1989
3. TIME OF DEATH: 9:00 A. M
4. SOCIAL SECURITY NUMBER: 218-09-0364
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-26-1918
8. BIRTHPLACE (State or Foreign Country): Baltimore Md.
9a. FACILITY NAME (If not institution, give street and number): 127 PARKIN ST.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. CITY
9c. COUNTY OF DEATH: /

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: /
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 127 Parkin St.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade — College (1-4 or 5+): /
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Meat Packing Plant
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Catherine Perry
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1708 Middletown Rd. Cheverly Md 20785
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East Rock Brentwood Cem.
20c. LOCATION — City or Town, State: Buttery Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Brown & Sons Inc Burial Vault
22. NAME AND ADDRESS OF FACILITY: John F. Brown & Sons Inc Rt. 214 Hallen & Bath Rd 21220

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Pulmonary embolus
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C.D. Kearney MD
29c. LICENSE NUMBER: D27860
29d. DATE SIGNED (Month, Day, Year): 9/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRISTOPHER D KEARNEY MD 700 WASH BLVD BALT MD
31. DATE FILED (Month, Day, Year): SEP 20 89
32. REGISTRAR'S SIGNATURE — Date: 21230

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROLAND WILKES ACTKINS | | | 2. DATE OF DEATH: MONTH 9 DAY 20 YEAR 89 | 3. TIME OF DEATH: 1:00 AM |
| 4. SOCIAL SECURITY NUMBER: 212-44-1067 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/02/37 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): JOHN HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2400 E. HOFFMAN STREET | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEKEEPER | 16b. KIND OF BUSINESS/INDUSTRY: JOHN HOPKINS HOSPITAL | |
| 17. FATHER'S NAME (First, Middle, Last): JULIUS ACTKINS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): VIRGINIA WILKES | |
| 19a. INFORMANT'S NAME (Type/Print): ALTORIA C. ACTKINS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 E. HOFFMAN STREET/BALTIMORE, MD 21213 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | Unknown |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Asthma DUE TO (OR AS A CONSEQUENCE OF): | YRS |
| | c. COPD DUE TO (OR AS A CONSEQUENCE OF): | YRS. |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| C. J. Folkner, M.D. | D14571 | ▶ 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. J. Folkner M.D., 4141 Mt. Rd., Pasadena, Md 21122

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 52231

89 25635

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DWIGHT ABELL | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: 4:00 P.M |
| 4. SOCIAL SECURITY NUMBER: 218-12-5153A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-5-1923 | 8. BIRTHPLACE (State or Foreign Country): Cumberland, Md. |
| 9a. FACILITY NAME (If not institution, give street and number): MARYLAND GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 747 Arncliffe Rd. | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LAB TECHNICIAN | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Vicky Ann Abell (daughter) Harbaugh | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 S. Olympia St. Clewiston, Fl, 33440 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUBURBAN CREMETORY | 20c. LOCATION — City or Town, State: SILVER SPRING, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roland P. Stabler Jr. | | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home, Inc 2134 Willow Spring Rd. Dundalk, Md. 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma of the Lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Shammi Rockove MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Shammi Rockove, M.D.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris Eileen Barton
2. DATE OF DEATH (Month, Day, Year): Sept. 20 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-30-0489
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): Dec. 15 1919
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1919 Kelmore Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Dundalk
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1919 Kelmore Ave.
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William Pramschufer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary V. Sparks
19a. INFORMANT'S NAME (Type/Print): Everette Barton Sr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1919 Kelmore Ave. Baltimore MAryland 21222
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cemetery
20c. LOCATION — City or Town, State: BAlto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: ConnellyFuneral Home of Dundalk 21222

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure - Terminal

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Chronic Renal Failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Severe Diabetes Mellitus

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Wall MD
29c. LICENSE NUMBER: D26835
29d. DATE SIGNED (Month, Day, Year): 9/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eastpoint Medical Center Balto. Md.

31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25637

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

5+1

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William Anthony Beresford, II. / William Beresford | | | | 2. DATE OF DEATH (Month, Day, Year) September 15, 1989 | 3. TIME OF DEATH 11:45 AM M |
| 4. SOCIAL SECURITY NUMBER 557-34-9833 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) Oct. 21, 1925 | 8. BIRTHPLACE (State or Foreign Country) New York |
| 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | | 9c. COUNTY OF DEATH Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Maryland | 10b. COUNTY Montgomery | 10c. CITY, TOWN OR LOCATION Wheaton | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER 4112 Elby Street | | 10f. ZIP CODE 20906 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronic Engineer | 16b. KIND OF BUSINESS/INDUSTRY E-Systems Melpar |
| 17. FATHER'S NAME (First, Middle, Last) William Anthony Beresford, I. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna May Leslie | |
| 19a. INFORMANT'S NAME (Type/Print) Susan Perpall | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 Ivy Lane-Vienna, Virginia 22181 | |
| 20a. METHOD OF DISPOSITION 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory | 20c. LOCATION — City or Town, State Alexandria, Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Melvin C. Powell | | 22. NAME AND ADDRESS OF FACILITY Money & King Funeral Home, Inc. 171 W. Maple Ave-Vienna, Virginia 22180 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Dilated Cardiomyopathy | 5 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): c. | Coronary Artery Disease | 5 yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Embolism

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER D. Goldberg | 29c. LICENSE NUMBER 02133 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel Goldberg, M.D. 10401 Old Georgetown Rd. Bethesda, Md.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) SEP 21 1989 | 32. REGISTRAR'S SIGNATURE Jacke Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ISADORE RAY BACH | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 17, 1989 | 3. TIME OF DEATH: 7 P.M. M |
| 4. SOCIAL SECURITY NUMBER: 489-03-2040 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JAN. 24, 1910 | 8. BIRTHPLACE (State or Foreign Country): MISSOURI |
| 9a. FACILITY NAME (If not institution, give street and number): 5513 OLD COURT ROAD 21207 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [XX] NO |
| 10e. STREET AND NUMBER: 5513 OLD COURT ROAD | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT | 16b. KIND OF BUSINESS/INDUSTRY: RETAIL | |
| 17. FATHER'S NAME (First, Middle, Last): ISRAEL BACH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HANNAH UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): MS. DEBRA SPUNT | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5513 OLD COURT RD. BALTO., MD 21207 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY-REISTERSTOWN, MD | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellsworth Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | CEREBROVASCULAR EVENT | 1 WEEK |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | ACUTE LEUKEMIA | 1 MONTH |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | MYELOFIBROSIS | 4 YRS |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: G.I.C. MD GARY COHEN, MD | 29c. LICENSE NUMBER: D 27730 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 711 W. 40th ST. BALTO MD. 21211 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

89 25639

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JACKIE F. BEVERLEY | | | 2. DATE OF DEATH (Month, Day, Year): 9-20-89 | 3. TIME OF DEATH: 8:12 AM |
| 4. SOCIAL SECURITY NUMBER: 216 32 8211 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-8-38 | 8. BIRTHPLACE (State or Foreign Country): ALABAMA |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: — | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 272 SOUTH EAST AVE. | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WAITRESS | 16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT | | |
| 17. FATHER'S NAME (First, Middle, Last): Herbert E. McSmith | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Clark | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Connie Wayne Kerr | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 272 South East Ave Balto Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount | 20c. LOCATION — City or Town, State: Balto. Maryland. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Bannino Jr. | 22. NAME AND ADDRESS OF FACILITY: Joseph N. Bannino Jr. F.H. 263 S. Conkling St. Balto Md | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SEPTIC SHOCK | DAYS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PERITONITIS | DAYS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | STRANGULATED HERNIA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA, MORBID OBESITY

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 6 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☒ NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| A. J. Helou, M.D | D17695 | ▶ 9-20-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.J. HELOU, M.D. CHURCH HOSPITAL 100 N. BROADWAY BALTO. MD 21231

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25639

89 25640

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dudley L. Carter (Pete) | | | 2. DATE OF DEATH: Month 9, Day 17, Year 89 | 3. TIME OF DEATH: 1105 AM |
| 4. SOCIAL SECURITY NUMBER: 251-42-5555 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 62 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-10-27 | 8. BIRTHPLACE (State or Foreign Country): SC |
| 9a. FACILITY NAME (If not institution, give street and number): Union Mem Hosp ECU | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto., Md. | | 9c. COUNTY OF DEATH: — |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: Balto. | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2720 Tivoly Ave | | 10f. ZIP CODE: 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): American St. Radio Co. | 16b. KIND OF BUSINESS/INDUSTRY: Disabled | | |
| 17. FATHER'S NAME (First, Middle, Last): Julius Carter | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hessie Taylor Carter | | |
| 19a. INFORMANT'S NAME (Type/Print): Odelle M. Carter | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2720 Tivoly Ave/Balto. MD. 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | | 22. NAME AND ADDRESS OF FACILITY: Wm. C. March Funeral Home 1101 E. North Avenue 21202 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of lung | 3 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| W.B. Daniels, Jr. M.D. | D-02225 | ▶ 9/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W.B. Daniels, Jr. M.D. Union Memorial Hospice Balto 21218

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25641

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FREDL. COUSIN Jr.
2. DATE OF DEATH (Month, Day, Year): 9 16 89
3. TIME OF DEATH: 1206 P M
4. SOCIAL SECURITY NUMBER: 218-18-5073A
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/14/23
8. BIRTHPLACE (State or Foreign Country): VA.
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1401 N. Lakewood Ave Apt 510 ~~510~~
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crane Operator
16b. KIND OF BUSINESS/INDUSTRY: Bethelem Steel Corp.
17. FATHER'S NAME (First, Middle, Last): Fred Cousin Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Sparrow
19a. INFORMANT'S NAME (Type/Print): Ruth Newton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3320 Lake Ave./Baltimore, MD 21213
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest VA Cem
20c. LOCATION — City or Town, State: Owings Mills, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner
22. NAME AND ADDRESS OF FACILITY: Wm. C. March Funeral Home 4701 E. North Avenue 21202

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Liver failure | 2-3 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cirrhosis | " |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Ethanol Use | 10 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Esophageal varices with bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: L.A. Cooper MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3900 Loch Raven Blvd. Baltimore, Md 21201
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25641

89 25642

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bernice Cook | | 2. DATE OF DEATH (Month, Day, Year): Sept. 16, 1989 | 3. TIME OF DEATH: 12:32P M |
| 4. SOCIAL SECURITY NUMBER: 215-14-0759 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 13, 1921 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 416 Edgewood Street | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier | 16b. KIND OF BUSINESS/INDUSTRY: Baltimore City Public Schools |
| 17. FATHER'S NAME (First, Middle, Last): Melvin Floinoy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): Lena R. Jenkins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 416 Edgewood Street Baltimore, Maryland 21229 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Nat'l Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Penny, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Squamous Cell Carcinoma, involving the lungs | |
| DUE TO (OR AS A CONSEQUENCE OF): | with respiratory failure. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Frank R Claudy MD | 29c. LICENSE NUMBER: D26438 | 29d. DATE SIGNED (Month, Day, Year): 9/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank Claudy, M.D. c/o Maryland General Hospita;

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Erika Davidson-Randall |

DHMH-16 Rev 1/89

09 2861S

UNKNOWN 89-171

Items:23 thru 28f per ME G-657
11-6-89 cm

89 25643

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH DAY YEAR | 3. TIME OF DEATH |
|---|---|---|---|---|
| JAMES | M. | COLOSIMO | 9-16-89 | 5:30PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 164 52 5799 | 1 [X] M 2 [ ] F | 26 YRS. | | | 8 13 63 | Trenton, NJ |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Piney Point Hollow-Potomac River | | St. Mary's County |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| PA. | Schuylkill | ZION GROVE | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| RTE. # 1 | 17985 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Seaman | Harry Lundburg School |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| George Colosimo | Dorothy Malacusky |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George Colosimo (Father) | Same as 10 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | St. Mary's Cemetery | Ringtown, PA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| David Sauls | Capitol Funeral Service<br>Falls Church, VA |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA<br>OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Water |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | 9-16-89 | M | 1 [ ] YES 2 [X] NO | UNKNOWN |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| IN WATER | Piney Point Hollow-Potomac River St. Mary's,Co.Md. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Wayne A. Dell Hill | OCME | ▶ 9-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, MD 111 Penn Street,Baltimore,MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Janice Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25644

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rena (Rita) Mae Dilworth (Dillsworth) | | | 2. DATE OF DEATH (Month, Day, Year): 9-18-89 | 3. TIME OF DEATH: 3:22 pM |
| 4. SOCIAL SECURITY NUMBER: 266-16-3693 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-1-1920 | 8. BIRTHPLACE (State or Foreign Country): Fla |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 806 Edmondson Avenue | | 10f. ZIP CODE: 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U S A |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): James Taylor | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Taylor | |
| 19a. INFORMANT'S NAME (Type/Print): Ernest Taylor | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3135 Oakford Avenue Baltimore, Md 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park | | 20c. LOCATION — City or Town, State: Randallstown, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Anne A. Thompson | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — Inspection | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St., Baltimore, MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25645

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edith Dunaway | | 2. DATE OF DEATH (Month, Day, Year): Sept. 16, 1989 | 3. TIME OF DEATH: 8:13A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jul 17, 1932 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1101 Lyndhurst Street | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): college 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Re Con Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Social Security Administra. |
| 17. FATHER'S NAME (First, Middle, Last): Robert Walker | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Jones | |
| 19a. INFORMANT'S NAME (Type/Print): Ira J. Dunaway | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1101 Lyndhurst Street Baltimore, Maryland 21229 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest X. Berry Jr | | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aneurysm of the aorta with rupture into the pericardium | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H. Grafsein | 29c. LICENSE NUMBER: N/a | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. Grafsein, M.D. c/o Maryland GEneral Hospital | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

89 25645

Item:23 thru 28f per ME G-656

FOR STATE REGISTRAR 10-18-89 cm

1 -

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25646
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): (Elliott) Radcliff P. (Radcliff) Elliott, Sr | | | | 2. DATE OF DEATH: MONTH 9 DAY 17 YEAR 89 | 3. TIME OF DEATH: 12:45 p M |
| 4. SOCIAL SECURITY NUMBER: 216-42-4001 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 47 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-31-1941 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): 2521 Reisterstown Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2521 Reisterstown Road | | 10f. ZIP CODE: 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Charles B. Dare | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances M. Elliott | | |
| 19a. INFORMANT'S NAME (Type/Print): Frances M. Dare | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2521 Reisterstown Road Balto, Md 21217 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | | 20c. LOCATION — City or Town, State: Arbutus, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Ebron | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Seizure disorder
DUE TO (OR AS A CONSEQUENCE OF):
b. Head injury (remote)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [XX] YES 2 [ ] NO | 1 [XX] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | UNKNOWN | M | 1 [ ] YES 2 [X] NO | UNKNOWN |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | UNKNOWN | | | UNKNOWN |

29a. CERTIFIER (Check only one) [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[XX] MEDICAL EXAMINER: On the basis of examination, and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | OCME | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St. Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25616

89 25647

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anita Edmonds | | | 2. DATE OF DEATH: MONTH 9 DAY 18 YEAR 89 | 3. TIME OF DEATH: 2152 M |
| 4. SOCIAL SECURITY NUMBER: 216-20-7289 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/18/26 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): UMMS | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Balto | 10c. CITY, TOWN OR LOCATION: Balto | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 911 Leadenhall St apt 603 | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic Work | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): NA | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NA |
| 19a. INFORMANT'S NAME (Type/Print): Earl Edmonds | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Leaden Hall St #603 Balto, Md 21230 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Arbutus Mem Park | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerome A. Thompson | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): b. Hypotension | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): c. Esophagectomy | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Esophageal perforation | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Patient is a Jehovah's witness and refused blood transfusion

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☒ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9/18/89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Department of Surgery UMMS | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25648

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dorothy Franklin | | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 15 / 89 | 3. TIME OF DEATH: 4:40 A.M. |
| 4. SOCIAL SECURITY NUMBER: 218-22-0542 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-28-1908 | 8. BIRTHPLACE (State or Foreign Country): MACyland |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER 2600 LIBERTY HEIGTS AVE. BALTO. 21215 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 2525 W. Belvedere Ave | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UnEmployed | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): N/A | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): N/A | | | |
| 19a. INFORMANT'S NAME (Type/Print): LISA | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Light Street Balto. MD 21202 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: Balto. City | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ L. P. Carroll | | 22. NAME AND ADDRESS OF FACILITY: Penn-Mitchell Funeral Home 1712-14 W. North Ave | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Septicemia DUE TO (OR AS A CONSEQUENCE OF): | 24 hr |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Infected decubitus @ Hip DUE TO (OR AS A CONSEQUENCE OF): | 1 wk |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hx Seizure disorder

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Amatun N. Nacom | D 15503 | ▶ 9/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 501 Dolphin St. Balto, MD 21217

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

OHMH-18 Rev 1/89

89 25649

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Jr Flowers
2. DATE OF DEATH (Month, Day, Year): 9 18 89
3. TIME OF DEATH: 4:31 PM
4. SOCIAL SECURITY NUMBER: 214-16-7353
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): April 28, 1924
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Good Samatarian Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: 4615 Marble Hall Road
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4615 Marble Hall Road
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintance Dept.
16b. KIND OF BUSINESS/INDUSTRY: Towson State College
17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Mace
19a. INFORMANT'S NAME (Type/Print): Genevieve Flowers
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4615 Marble Hall Road Baltimore, Maryland 21239
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran Cem
20c. LOCATION — City or Town, State: Baltimore, County, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Rollins
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Guyuns Falls Pkwy. Baltimore, Maryland 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on aach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | aspiration | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | vomiting | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | — | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: lung cancer

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [✓] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year):
26b. TIME OF INJURY:
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED:
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samer Dibs, M.D. Good Samaritan Hospital of Maryland
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene [illegible] to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other b[illegible] the medical examiner must be notified at once.

4 7 189 70 87 A

89 25650

1 FOR STATE REGISTRAR GRINNAN, FLOSSIE E

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FLOSSIE E. GRINNAN | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 15, 1989 | 3. TIME OF DEATH: 4:45A M |
| 4. SOCIAL SECURITY NUMBER: 230-40-2465 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JUNE 28 1934 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5476 CEDONIA AVENUE | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEKEEPING DEPT | 16b. KIND OF BUSINESS/INDUSTRY: BALTO. COUNTY SCHOOLS | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM GRINNAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ADLISSA LACKS | |
| 19a. INFORMANT'S NAME (Type/Print): JANET GREENE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5468 BUCKNELL RD, BALTO., MD. 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LACKSTOWN CEMETERY | 20c. LOCATION — City or Town, State: CLOVER, VIRGINIA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frances C. Evans | 22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CEREBRAL VASCULAR ACCIDENT | HOURS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | END STAGE MULTIPLE MYELOMA | > 2Y. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SPINAL CORD COMPRESSION

PEPTIC ULCER DISEASE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A.C. WOLFF, MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 09/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 600 N. WOLFE ST, BALTIMORE. | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B11

89 25651

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CLIFTON J. GAVIN | | | 2. DATE OF DEATH (Month, Day, Year): 9 19 89 | 3. TIME OF DEATH: 5 45 P M |
| 4. SOCIAL SECURITY NUMBER: 215-10-5850 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-25-13 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTO. CO. |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTO. CO. | 10c. CITY, TOWN OR LOCATION: PARKVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7703 CHESTNUT AVE | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W.II, KOREAN | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — ~~American Indian, Black,~~ White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN | 16b. KIND OF BUSINESS/INDUSTRY: BALTO. GAS & ELEC. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH GAVIN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA TILLHOF |
| 19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEM. | 20c. LOCATION — City or Town, State: PARKVILLE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thos L. Gain | 22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL 8800 HARFORD RD. PARKVILLE | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SEVERE CHRONIC OBSTRUCTIVE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. PULMONARY DISEASE.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A.H. Ghiladi, M.D. | 29c. LICENSE NUMBER: D12849 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-19-89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ~~24~~ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 52221

89 25652

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian E Haines | | 2. DATE OF DEATH: MONTH 9 DAY 21 YEAR 89 | 3. TIME OF DEATH: 7:20 A M |
| 4. SOCIAL SECURITY NUMBER: 150-34-6199 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2 7 1917 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklyn Square | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore, Co. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Perry Hall | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 21 Lincoln Woods Way | 10f. ZIP CODE: 21128 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress | 16b. KIND OF BUSINESS/INDUSTRY: Nooneys Restaurant |
| 17. FATHER'S NAME (First, Middle, Last): Henry — Sands | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Rose Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Colter | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Lincoln Woods Way Perry Hall 21128 Md. | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenwood | 20c. LOCATION — City or Town, State: Cedar Run N. J | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A. Chojnacki | | 22. NAME AND ADDRESS OF FACILITY: Mark A. Chojnacki 1800 E. Lombard St. Balto. Md 21231 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis (uro) — 9-20-89

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Pamela L. Farmer | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-22-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Pamela L. Farmer | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25653

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Catherine Harrison | | | | | 2. DATE OF DEATH (Month, Day, Year): 9/19/89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 219 16 6927 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/8/24 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 10 Otley Ct. Apt 2B | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 10 Otley Ct. Apt 2B | | | 10f. ZIP CODE: 21207 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic | | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Willie Johnson | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Letha Ann Scott | |
| 19a. INFORMANT'S NAME (Type/Print): Veronica Valentine | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Otley Ct. Apt. 2B Balto., Md. 21207 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park | | | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | | | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens Street Balto., Md. 21217 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC BREAST CA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Stephen W. Glasser M D | D-20492 | 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN A. GLASSER MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

9/20/89

DHMH-16 Rev 1/89

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89 25654

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PARKER HOWARD / Parker Louis Howard | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 18 / 89 | 3. TIME OF DEATH: 245 P M |
| 4. SOCIAL SECURITY NUMBER: 213-10-2029 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 17, 1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): FSKMC 4940 EASTON AVE. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD | | 9c. COUNTY OF DEATH: BALTO. CITY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: BAltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: P.O. Box 4053 | | 10f. ZIP CODE: 21222-0053 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: Armco Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Parker M. Howard | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REbecca Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): Edna C. Howard | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 4053 BAltimore MAryland 21222-0053 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore MAryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MAceAve. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPOTENSION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. SEPSIS AND

DUE TO (OR AS A CONSEQUENCE OF):

c. POSSIBLE MYOCARDIAL ISCHEMIA

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE ON HEMODIALYSIS

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: BRIAN LEWIS, M.D. RESIDENT, M.D. | 29c. LICENSE NUMBER: J3F091 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRIAN LEWIS, FSKMC | | |
| 31. DATE FILED (Month, Day, Year): 9/18/89 SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25655

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Warren Hash | | 2. DATE OF DEATH (Month, Day, Year): September 20, 1989 | 3. TIME OF DEATH: 10:30am |
| 4. SOCIAL SECURITY NUMBER: 228-14-3889 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1922 / 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): 175 Langley Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Essex | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: BAltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 175 Langley Road | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrical | 16b. KIND OF BUSINESS/INDUSTRY: Rockingham Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Wiley L Hash | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Miller | | |
| 19a. INFORMANT'S NAME (Type/Print): Mildred Hash | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 175. Langley Road BAlto. Maryland 21221 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Laurel Springs Cemetery | 20c. LOCATION — City or Town, State: Marion Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MAceAve. 21221 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Malnutrition | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Recurrent advanced Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Wm Richtsmeier | 29c. LICENSE NUMBER: D 32797 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wm Richtsmeier Johns Hopkins Hospital, Baltimore Md

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25656

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Milton Henry Huntt Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 20 1989 | 3. TIME OF DEATH: 6:50pm M |
| 4. SOCIAL SECURITY NUMBER: 212-01-6856 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug. 21, 1910 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 80 W. Kingston Park Lane | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Middle River | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 80 W. Kingston Park Lane | | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Huntt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Kiefner | |
| 19a. INFORMANT'S NAME (Type/Print): Milton Huntt Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Kingston Road Baltimore MAryland 21220 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Balto. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAve. 21221 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastate prostate Carcinoma.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NA | 28b. TIME OF INJURY: NA M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO NA | 28d. DESCRIBE HOW INJURY OCCURED: NA |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jeffrey A Cool MD | 29c. LICENSE NUMBER: D 24650 | 29d. DATE SIGNED (Month, Day, Year): 9/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey A Cool MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25657

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

6

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAK HAAK Max R. Haak | | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 16, 1989 | 3. TIME OF DEATH: 2:59 pM |
| 4. SOCIAL SECURITY NUMBER: 094 09 2831 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 25, 1916 | 8. BIRTHPLACE (State or Foreign Country): Little Falls, NY |
| 9a. FACILITY NAME (If not institution, give street and number): University of Maryland Medical Systems | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: n/a | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 301 Kentucky Ave. | | 10f. ZIP CODE: 21122 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plant Engineer | | 16b. KIND OF BUSINESS/INDUSTRY: Trico Fabric Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Haak | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Youngblut | | | |
| 19a. INFORMANT'S NAME (Type/Print): Bernadine Haak (wife) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, VA | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David L. Sauls | 22. NAME AND ADDRESS OF FACILITY: Capitol Funeral Service Falls Church, VA | | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MULTIPLE ORGAN FAILURE | 10 d |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. SEPSIS | 3-7 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS
HEART FAILURE S/P CORONARY ARTERY BYPASS GRAFT

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | | 9/16/89 4:07P |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Geoffrey Shlak MD UMMS 22 S. Greene St

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25651

T 066 51 60 A
HESS, FREDERICK
02/16/15 M

10

89 25658

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| FREDERICK HESS | | SEPTEMBER 16, 1989 | 5:54A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-03-4083 | 1 [X] M 2 [ ] F | 74 YRS. | | | FEB. 16, 1915 | GERMANY |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | BALTO. | BALTIMORE | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 6607 DEANCROFT ROAD | 21209 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES WWII | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | OWNER | HESS DRESS COMPANY |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| ALBERT HESS | BERTHA WERTHEIM |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. EVELYN HESS | 6607 DEANCROFT ROAD BALTO.,MD. 21209 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | CHEVRA AHAVAS CHESED | RANDALLSTOWN |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Jacob H Levinson | SOL LEVINSON AND BROS.,INC 6010 REISTERSTOWN RD. BALTO.,MD. 21215 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Dysfunction | 8 Hrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial Infarction | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Artery Disease | 15 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Diabetes Mellitus | 10 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Lymphocytic Leukemia

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Timothy P. Codd MD | AA434 JHH | ▶ 9/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Timothy P. Codd 600 N. Wolfe St. Balt. MD 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Esther Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

12

89 25659

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/cremation permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MORRIS REUBEN HELLER | | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 13, 1989 | 3. TIME OF DEATH: 10:20 P.M. |
| 4. SOCIAL SECURITY NUMBER: 141-28-8441 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 95 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JULY 26, 1894 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): PIKESVILLE NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [XX] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5009 FALLS ROAD | | 10f. ZIP CODE: 21210 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUILDER | 16b. KIND OF BUSINESS/INDUSTRY: REAL ESTATE |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH HELLER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE (UNKNOWN) | |
| 19a. INFORMANT'S NAME (Type/Print): JANET HELLER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5009 FALLS ROAD BALTO., MD 21210 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BNAI JESHURUN CEMETERY | 20c. LOCATION — City or Town, State: NEWARK, NEW JERSEY |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Parkinsons | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Dementia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Flexion Contractures | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CVA's | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Claudia Levi MD | 29c. LICENSE NUMBER: D27075 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 10219 S Dolfield Rd. Owings Mills MD 21117 | | |
| 31. DATE FILED (Month, Day, Year): 9 SEP 25 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25660
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MINNIE JOSEPH

**2. DATE OF DEATH** (Month, Day, Year): 9 17 89

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 212-24-9320

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 74 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 9-8-15

**8. BIRTHPLACE** (State or Foreign Country): N.C.

**9a. FACILITY NAME** (If not institution, give street and number): 933 McALEER COURT

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE CITY

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 933 McALEER COURT

**10f. ZIP CODE**: 21202

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ ND Specify:

**14. RACE** — American Indian, Black, White, etc.
Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): UNKNOWN
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): REGISTER NURSE

**16b. KIND OF BUSINESS/INDUSTRY**: J.H.H.

**17. FATHER'S NAME** (First, Middle, Last): JOSEPH HARDY

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): MARY EBRON

**19a. INFORMANT'S NAME** (Type/Print): JEAN ALLISON

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3429 ELMORA AVENUE/BALTIMORE, MD. 21213

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Arbutus Memorial Park Cemetery

**20c. LOCATION — City or Town, State**: Arbutus, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: WM. C. MARCH F.H. 1101 E. NORTH AVENUE 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. [illegible] Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
c. Carotid obstruction bilaterally
DUE TO (OR AS A CONSEQUENCE OF):
d. Advanced Cervical Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ ND

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Jonathan L. Leake MD

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 9/19/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): J. LEAKE 439 S. CHESTER BALT MD

**31. DATE FILED** (Month, Day, Year): SEP 21 1989

**32. REGISTRAR'S SIGNATURE**: Julie Davidson-Kemp 2123/

DHMH-16 Rev 1/89

89 25661

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Keith B. (Jennifer) Jenifer, Sr | | | | 2. DATE OF DEATH: MONTH 9 DAY 18 YEAR 89 | 3. TIME OF DEATH: 3:23 p M |
| 4. SOCIAL SECURITY NUMBER: 216-86-9612 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 26 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-28-1962 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2727 Riggs Avenue | | 10f. ZIP CODE: 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Karl Jenifer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Joan Brown | | | |
| 19a. INFORMANT'S NAME (Type/Print): Gwendolyn Stewart | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2727 Riggs Avenue Baltimore, Md 21216 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | | 20c. LOCATION — City or Town, State: Arbutus, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dola March | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Contact Gunshot Wound of Head
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 [ ] NO | XX YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 XX ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 XX Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 9-18-89 | 3:00p M | 1 [ ] YES 2 [X] NO | Subject Shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1100 Poplar Grove St. |

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | ocme | ▶ 9-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D., 111 Penn Street Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25662

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Benjaman Johnson | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 18 / 89 | 3. TIME OF DEATH: 0005 AM |
| 4. SOCIAL SECURITY NUMBER: 227-30-6378 | 5. SEX: 1 [X] M 2 [ ] F | 8. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 6, 1928 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3309 Brighton Street | | 10f. ZIP CODE: 21216 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): college 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Amstar Corporation |
| 17. FATHER'S NAME (First, Middle, Last): Harriosn Johnson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Britton | |
| 19a. INFORMANT'S NAME (Type/Print): Marion B. Johnson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3309 Brighton Street Baltimore, Maryland 21216 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran Cem | 20c. LOCATION — City or Town, State: Baltimore County, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Emery, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of The Lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. COPD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ahmed Husavi | 29c. LICENSE NUMBER: D37353 | 29d. DATE SIGNED (Month, Day, Year): 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Ahmed Husavi MD Liberty medical center | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

89 2662

5

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25663

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ABRAHAM ~~ABRAHAM~~ KIRSCHENBLUTH ~~KIRSCHENBLUTH~~ | | | | 2. DATE OF DEATH: MONTH 9 DAY 16 89 (AM/PM) | | 3. TIME OF DEATH: 1:00 P M |
| 4. SOCIAL SECURITY NUMBER: 111-07-7393 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 12, 1907 | | 8. BIRTHPLACE (State or Foreign Country): POLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 2500 W. BELEVEDERE AVE. APT. 610 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2500 W. BELEVEDERE AVE. APT. 610 | | | 10f. ZIP CODE: 21215 | | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW2 | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER | | 16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT | | |
| 17. FATHER'S NAME (First, Middle, Last): EMANUEL KIRSCHENBLUTH | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GOLDA DUMPS | | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. RITA MORRIS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9345 CORNSHOCK COURT COLUMBIA, MD. 21045 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH ISRAEL | | 20c. LOCATION — City or Town, State: WOODBRIDGE, NEW JERSEY | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Levin | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON AND BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD. 21215 | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ATHEROSCLEROTIC HEART DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Simeon L. Bardin | D25695 | ▶ 9-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Simeon L. Bardin 2435 W. Belvedere Ave Baltimore Md 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25664

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BLANCHE KAPLAN | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 17, 1989 | 3. TIME OF DEATH: 2:45 AM |
| 4. SOCIAL SECURITY NUMBER: 216-44-0575 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 7, 1899 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): JEWISH CONVALESCENT HOME | 9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE | 9c. COUNTY OF DEATH: BALTIMORE | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: PIKESVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7903 CRISFORD PLACE | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKER | |
| 17. FATHER'S NAME (First, Middle, Last): HARRY LAMPE | 16. MOTHER'S NAME (First, Middle, Maiden Surname): MARY WHITE | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. HARRIETT E. WEISBERG | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3031 FALLSTAFF RD. APT. 604C BALTO., MD. (21209) | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON CEMETERY | 20c. LOCATION — City or Town, State: BALTO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stallman | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. arteriosclerosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jerome H. Ginsberg M.D. | 29c. LICENSE NUMBER: D20964 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JEROME H. GINSBERG, M.D. 8630 Liberty Plaza Mall Randallstown, Md. 21133 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

b

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25665
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the final report. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Carl Klein — CARL KLEIN
**2. DATE OF DEATH** (Month, Day, Year): 9 / 17 / 89
**3. TIME OF DEATH**: 10 PM
**4. SOCIAL SECURITY NUMBER**: 213-34-4951
**5. SEX**: 1 [X] M 2 [ ] F
**6. AGE** (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
**7. DATE OF BIRTH** (Month, Day, Year): NOV. 4, 1900
**8. BIRTHPLACE** (State or Foreign Country): ROUMANIA
**9a. FACILITY NAME** (If not institution, give street and number): Sinai Hospital
**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore MD
**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD
**10b. COUNTY**: Baltimore
**10c. CITY, TOWN OR LOCATION**:
**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO
**10e. STREET AND NUMBER**: 6996 MILBROOK PARK DR. APT. T-1
**10f. ZIP CODE**: 21215
**10g. CITIZEN OF WHAT COUNTRY?**: USA
**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES X
**13. WAS DECEDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
**14. RACE — American Indian, Black, White, etc.** Specify: White
**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT
**16b. KIND OF BUSINESS/INDUSTRY**: RETAIL
**17. FATHER'S NAME** (First, Middle, Last): UNKNOWN KLEIN
**18. MOTHER'S NAME** (First, Middle, Maiden Surname): YETTA UNKNOWN
**19a. INFORMANT'S NAME** (Type/Print): MRS. SHELDON HYMOWITZ
**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2455 FOREST GREEN RD. BALTO., MD 21209
**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP
**20c. LOCATION — City or Town, State**: BALTO., MD
**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**:
**22. NAME AND ADDRESS OF FACILITY**: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. (1) SUBDURAL HEMATOMA & PARIETAL HEMORRHAGE — DUE TO (OR AS A CONSEQUENCE OF): | 24 D |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. FALL TRAUMA — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Mild
A-fib

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO
**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO
**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [X] YES 2 [ ] NO
**26. PLACE OF DEATH** (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
**27. MANNER OF DEATH**: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
**28a. DATE OF INJURY** (Month, Day, Year): 9/16/89
**28b. TIME OF INJURY**: M
**28c. INJURY AT WORK?** 1 [ ] YES 2 [X] NO
**28d. DESCRIBE HOW INJURY OCCURED**: fall in nursing home
**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify): Rockville nursing home
**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
**29b. SIGNATURE AND TITLE OF CERTIFIER**: MD
**29c. LICENSE NUMBER**:
**29d. DATE SIGNED** (Month, Day, Year): 9/20/89
**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): PATRICIA GAIL ROBERTS MD
**31. DATE FILED** (Month, Day, Year): SEP 21 1989
**32. REGISTRAR'S SIGNATURE**: Gisha Davidson-Randall

DHMH-16 Rev 1/89

89 25666

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Margaret V. Lee | | | 2. DATE OF DEATH (Month, Day, Year): 9 18 89 | 3. TIME OF DEATH: 11:20 a M |
| 4. SOCIAL SECURITY NUMBER: 212 22 7026 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/23/22 | 8. BIRTHPLACE (State or Foreign Country): Va. |
| 9a. FACILITY NAME (If not institution, give street and number): 816 Bonaparte Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 606 S. Fulton Avenue | | 10f. ZIP CODE: 21223 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook | | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant |
| 17. FATHER'S NAME (First, Middle, Last): Mack Campbell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Campbell Lawrence | | |
| 19a. INFORMANT'S NAME (Type/Print): Maxine Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 816 Bonaparte Ave. Balto., Md. 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ~~Arbutus~~ Cemetery | | 20c. LOCATION — City or Town, State: Balto. Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cirrhosis of Liver | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic Alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO Inspection | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St., Baltimore, MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Kennedy | |

DHMH-16 Rev 1/89

89 25667

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Frank | H. | Lomax Sr. | 9 / 16 / 89 | 10:30 p M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-01-5175 | 1 ☐ M 2 ☐ F XX | 72 YRS. | | | 8 27 17 | South Carolina |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATN |
|---|---|---|
| 1002 N. Monroe St. | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1002 N. Monroe Street | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Construction Laborer | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John Lomax | Mattie Barton |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard Lomax | 5004 Plainfield Ave. Balto.,Md 21206 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Arbutus Memorial Park | Arbutus, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Leroy Harris | 1701 McCulloh St. Chatman-Harris F/H BAlto., Md 21217 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO XX | 1 ☐ YES 2 ☒ NO XX |

Inquiry

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| 1 ☒ YES XX 2 ☐ NO | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | 4 ☐ Nursing Home 5 ☒ Residence XX 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural XX 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER XXX: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)
Ann M. Dixon, M.D. 111 Penn St. Baltimore,MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25668

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/cremation permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mamie Loebrick | | 2. DATE OF DEATH (Month, Day, Year): 9-18-89 | 3. TIME OF DEATH: 730 A M |
| 4. SOCIAL SECURITY NUMBER: 231-05-0080 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/1/1911 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Balto. Co. General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7600 Clays Lane Apt. 209 | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: --------- | |
| 17. FATNER'S NAME (First, Middle, Last): William S. Hawker | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Nannie Murray | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Jane Shelton | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT 1 Box 40 Keeling VA 24566 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M. Jenkins | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sie Kien Ong MD House Physician | 29c. LICENSE NUMBER: D36456 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sie Kien Ong MD. Baltimore County General Hospital, Randallstown. MD. 21133 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25669

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

12

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James I. Lankford, Jr. | | | | 2. DATE OF DEATH (Month, Day, Year): 9-16-89 | 3. TIME OF DEATH: 5:45 p.M |
| 4. SOCIAL SECURITY NUMBER: 214-42-9486 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 45 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | | 7. DATE OF BIRTH (Month, Day, Year): 08-16-44 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Edw. W. McCready Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Crisfield | | 9c. COUNTY OF DEATH: Somerset | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Somerset | 10c. CITY, TOWN OR LOCATION: Crisfield | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Rt. 1 - Box 414 A - Lawsonia | | 10f. ZIP CODE: 21817 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H.S. graduate; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman | 16b. KIND OF BUSINESS/INDUSTRY: Building Supplies | |
| 17. FATHER'S NAME (First, Middle, Last): James I. Lankford, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Marshall | |
| 19a. INFORMANT'S NAME (Type/Print): Vivian Lankford | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10 abcdef | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): American Legion Cemetery | 20c. LOCATION — City or Town, State: Crisfield, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert H. Bradshaw | | 22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons, Main St., Crisfield, Md. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Amyotrophic Lateral Sclerosis | 4y |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. D. Barhan | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. M. D. Barhan, Rt. #413, Crisfield, Md. 21817

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25669

Item [illegible] grim G855
9-21-89 I.J.

89 25670

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LESTER LEVY | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 19, 1989 | 3. TIME OF DEATH: 12:40 A. M |
| 4. SOCIAL SECURITY NUMBER: 215-10-0970 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): OCT. 22, 1896 — 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): 2 SLADE AVE. #21208 | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2 SLADE AVE. | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWI | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EXECUTIVE | 16b. KIND OF BUSINESS/INDUSTRY: HAT MANUFACTURER | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM LEVY | 18. MOTHER'S NAME (First, ~~STEIN~~ STERN): BEATRICE ~~STEIN~~ | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. ELEANOR K. LEVY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 SLADE AVE BALTO., MD 21208 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellensue Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CHRONIC CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOSCLEROTIC VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. SENILITY
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: N.A

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] ND

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| NA | NA M | 1 [ ] YES 2 [ ] NO | NA |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Anthony Perlman | D09992 | ▶ 9/19/89 |

30. NAME AND ADDRESS OF ~~PERSON WHO COMPLETED CAUSE OF DEATH~~ (ITEM 27) (Type, Print): DR. ANTHONY PERLMAN, 204 E JOPPA RD, BALTO. MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Jane Dorsey-Kinder |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25671 — REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Emma LUCILLE MC WILLIAMS | | | 2. DATE OF DEATH: MONTH 09 DAY 15 YEAR 89 | 3. TIME OF DEATH: 11PM M |
| 4. SOCIAL SECURITY NUMBER: 222-16-8123 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 04 26 98 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGES |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Greenbelt | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7010 Greenbelt Road | | 10f. ZIP CODE: 20770 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -6- — College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Franklin Mills | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Catherine Martz | |
| 19a. INFORMANT'S NAME (Type/Print): Helen McWilliams (Daughter-In Law) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4917 49th Avenue, Hyattsville, Maryland 20781 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lacey Spring Cemetery | | 20c. LOCATION — City or Town, State: Rockingham Co., Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Howard A Causan — MD # M00690 | | 22. NAME AND ADDRESS OF FACILITY: Lindsey Funeral Homes, Inc. 473 S. Main Street, Harrisonburg, VA 22801 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sinus Arrhythmia.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Coronary Insufficiency.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Status Post Cerebrovascular Accident; Atrial Fibrillation; Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURRED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart Turkewitz MD — 29c. LICENSE NUMBER: D31001 — 29d. DATE SIGNED (Month, Day, Year): ▶ 9/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stuart J. Turkewitz — 7500 Greenway Cntr. Dr. Greenbelt, Md. 20770.

31. DATE FILED (Month, Day, Year): SEP 21 1989 — 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

#10 per FH-gHD
12/15/89 KM

89 25672

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| Samuel A. Metz Sr. | Sept. 14, 1989 | 2:15 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| [illegible] | XX 1 M 2 F | 91 YRS. | | | May 28, 1898 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Moran Manor Care Center | Westernport | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Allegany | Barton | 1 X YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Rt. 1, Box 73 | 21521 | USa |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 XX NO | 1 ☐ YES 2 X NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 8 +) | | |
| n/a | | Ret. Miner | Coal |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William J. Metz | Ellen Poland |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Luther Metz | Barton, Md. 21521 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | Laurel Hill Cemetery | Barton, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ F. Wayne Boal Jr | Boal-Warnick Funeral Home Barton, Md. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Generalized Debility + Stroke | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [illegible] M.D. | D212 44 | ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25673

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Enes R. Marcin | | | 2. DATE OF DEATH: MONTH 9 DAY 20 YEAR 89 | 3. TIME OF DEATH: 2:45 A M |
| 4. SOCIAL SECURITY NUMBER: 213-03-5968 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-24-1913 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Fallston General Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Fallston, Md. | | 9c. COUNTY OF DEATH: Harford |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk, Md. | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8231 Long Point Rd. | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Angelo J. Franks | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dena M. Fioretto | |
| 19a. INFORMANT'S NAME (Type/Print): Brian Marcin (Son) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1531 Harford Sq. Dr. Edgewood, Md. 21040 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. 21237 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter S. Cadden Magill | | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. NON SMALL CELL LUNG CANCER | ~8 MON |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | | ▶ 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN PEDWALDS 5112 BELAIR RD FALLSTON, MD 21047

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | John Davidson-Randall |

DHMH-16 Rev 1/89

B

89 25674

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): (NEJATOLLAH MELAMED) MELAMED, NEJATOLLAH | | | 2. DATE OF DEATH: MONTH 09 DAY 15 YEAR 89 | 3. TIME OF DEATH: 4:10 AM |
| 4. SOCIAL SECURITY NUMBER: 218 21 4415 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/6/27 |
| 8. BIRTHPLACE (State or Foreign Country): IRAN | | | | |
| 8a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6510 PARK HTS. AVE, APT. 2D | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES | 16b. KIND OF BUSINESS/INDUSTRY: CLOTHING | |
| 17. FATHER'S NAME (First, Middle, Last): NADAV MELAMED | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ZAGHI UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. MAHIN MELAMED | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6510 PARK HTS. AVE, APT. 2D BALTIMORE, MD 21215 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 XX Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EDEN MEMORIAL PARK | 20c. LOCATION — City or Town, State: MISSION HILLS, CA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: GASTRIC CANCER

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BEHRINGER MD SINAI HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BELLA MEYER | | | 2. DATE OF DEATH (Month, Day, Year): 9 17 89 | 3. TIME OF DEATH: 9:00 P M |
| 4. SOCIAL SECURITY NUMBER: 042-60-5520 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 39 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): DEC. 18, 1949 | 8. BIRTHPLACE (State or Foreign Country): ROMANIA |
| 9a. FACILITY NAME (If not institution, give street and number): Easton Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | | 9c. COUNTY OF DEATH: Talbot |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8 CALYPSO COURT | | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WNAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: XX | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5 +): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): REGISTERED NURSE | 16b. KIND OF BUSINESS/INDUSTRY: LOCH RAVEN V.A. HOSP. |
| 17. FATHER'S NAME (First, Middle, Last): MOSHE HAIMOVICH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): DR. EUGENE MEYER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 CALYPSO CT. BALTO., MD 21209 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LUBAWITZ NUSACH ARI | 20c. LOCATION — City or Town, State: ROSEDALE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multiple injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-17-89 | 28b. TIME OF INJURY: 7:58P M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: pedestrian struck by auto | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): highway | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 404 westbound, west of River road, Talbot, Co. | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street Baltimore, MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT SEFF OFFIT | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 18, 1989 | 3. TIME OF DEATH: 6:50 AM |
| 4. SOCIAL SECURITY NUMBER: 217-54-9356 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 31 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DEC. 12, 1957 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 3812 TUDOR ARMS AVE 21211 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3812 TUDOR ARMS AVE. | | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 6+): 4 | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): VICE PRESIDENT | 16b. KIND OF BUSINESS/INDUSTRY: R.S. PROPERTIES |
| 17. FATHER'S NAME (First, Middle, Last): HOWARD OFFIT | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JOANBETTE SEFF | |
| 19a. INFORMANT'S NAME (Type/Print): HOWARD OFFIT | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8202 TALL CHIMNEY CT. BALTO., MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. A.I.D.S | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Jeffrey L. Quartner | D21128 | ▶ 9/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Jeffrey L. Quartner MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Esther Davidson-Randall |

DHMH-16 Rev 1/89

89 25677

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Bertram Powell Powell | | | 2. DATE OF DEATH MONTH 9 DAY 19 YEAR 89 | 3. TIME OF DEATH 12:01 A.M. M |
| 4. SOCIAL SECURITY NUMBER 217-16-4749A | 5. SEX 1 M 2 F | 6. AGE (In yrs. last birthday) 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 9-29-1900 |
| 8. BIRTHPLACE (State or Foreign Country) Baltimore | | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH Frederick County , Md. | 9c. COUNTY OF DEATH Frederick |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Md. | 10b. COUNTY Frederick | 10c. CITY, TOWN OR LOCATION Frederick | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER 7475 Betsy Ross Drive-Frederick, Md. | 10f. ZIP CODE 21701 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: N/A | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Mechanic | 16b. KIND OF BUSINESS/INDUSTRY Self-Employed | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) Henry Harry Powell | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret ? |
| 19a. INFORMANT'S NAME (Type/Print) Mr.John K. Powell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 785 Long Corner Rd.-Mt. Airy, Md. #21771 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 9-20-89 1 Burial 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | 20c. LOCATION — City or Town, State Baltimore, Md. #21229 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ G. Truman Schwab | 22. NAME AND ADDRESS OF FACILITY 3512 Frederick Avenue Baltimore, Md. #21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease — several years.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Andrew Zantek, MD | 29c. LICENSE NUMBER D35164 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Andrew Zantek, Jr, MD 29 E. Frederick St Walkersville MD 21793

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) SEP 21 1989 | 32. REGISTRAR'S SIGNATURE Jacke Davidson-Randall |

DHMH-18 Rev 1/89

89 25678

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSEMARY FRANCES PLUNKERT | | 2. DATE OF DEATH (Month, Day, Year): Sept. 20 1989 | 3. TIME OF DEATH: 2 00 P M |
| 4. SOCIAL SECURITY NUMBER: 218.78.1846 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 7, 1943 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: City | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8421 Bussenius Road | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): – College (1-4 or 5+): – | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): James Henry Plunkert | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Elizabeth Myers | | |
| 19a. INFORMANT'S NAME (Type/Print): James Plunkert | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 249, Box 67, Callaway, Maryland 20620 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ D L Howalter | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 2106 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. METASTATIC ADENOCARCINOMA BREAST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentielly list conditions, if any, leading to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in desth) LAST | b. Hepatic Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Hypercalcemia | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas Rivera | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Rivera | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 25679

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eva F. Russ | | | 2. DATE OF DEATH (Month, Day, Year): September 18, 1989 | 3. TIME OF DEATH: 11:39 PM |
| 4. SOCIAL SECURITY NUMBER: 217-20-2551 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 7, 1905 | 8. BIRTHPLACE (State or Foreign Country): MAryland |
| 9a. FACILITY NAME (If not institution, give street and number): Church Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: BAltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3511 Dunhaven Road | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 18b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): George C. Ortel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise C. Strauss | |
| 19a. INFORMANT'S NAME (Type/Print): Barbara Singleton | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3511 Dunhaven Road Baltimore MAryland 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Louden Park Cemetery | 20c. LOCATION — City or Town, State: BAltimore MAryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): | Immediate |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Post operative — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. #10 Fx of (R) hip & surgery DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, ASCVD, CHF,

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible], M.D. | 29c. LICENSE NUMBER: D-17902 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. S. BANG M.D 101 St Helena Ave Baltimore Md 21222 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25680

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Linda D. Rice
2. DATE OF DEATH: MONTH 9 DAY 13 YEAR 89
3. TIME OF DEATH: 2 10 PM
4. SOCIAL SECURITY NUMBER: 218-80-5732
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 32 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-17-56
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Mason Filord
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: Balto. City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Balto.
10c. CITY, TOWN OR LOCATION: Randallstown
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3834 Brownhill Rd.
10f. ZIP CODE: 21133
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Melvin Rice
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dolores M. Young
19a. INFORMANT'S NAME (Type/Print): Dolores M. Rice
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3834 Brownhill Rd. Randallstown, Md. 21133
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Mem. Park
20c. LOCATION — City or Town, State: Randallstown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris
22. NAME AND ADDRESS OF FACILITY: Chatman-Harris FH 21217 1701 McCulloh St. Balto. Md

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia — 10days
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
mental retardation with hydrocephalus and seizure disorder since birth; on chronic tube feeding; history of chronic infections

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Susan Denman M.D.
29c. LICENSE NUMBER: D 23584
29d. DATE SIGNED (Month, Day, Year): ▶ 9/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S Denman MD. 5200 Eastern Ave Balt Md 21224
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

89 25681

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Herman Rosenberger | | | 2. DATE OF DEATH (Month, Day, Year): 9-14-89 | 3. TIME OF DEATH: 7:29PM M |
| 4. SOCIAL SECURITY NUMBER: 066-10-5903 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): JAN. 11, 1906 | 8. BIRTHPLACE (State or Foreign Country): GERMANY |
| 9a. FACILITY NAME (If not institution, give street and number): 6600 Vincent Lane APT. 202 (21215) | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6600 VINCENT LANE, APT. 202 | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC | | 16b. KIND OF BUSINESS/INDUSTRY: CATS PAW RUBBER CO. |
| 17. FATHER'S NAME (First, Middle, Last): ANTON ROSENBERGER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNE UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. THEA ROSENBERGER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6600 VINCENT LA, APT. 202 BALTO., MD 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO CEMETERY | | 20c. LOCATION — City or Town, State: BALTO., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sol D Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter tha mode of dying, auch as cardiac or reapiratory arreat, shock, or heart feilure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES XX NO | |
| | INQUIRY | | |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home XX Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 vc | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25682
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANKIE RAYMOND
2. DATE OF DEATH: MONTH 09 DAY 17 YEAR 89
3. TIME OF DEATH: 23:52 M
4. SOCIAL SECURITY NUMBER: 218-46-5442
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 46 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-10-43
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University Of MAryland Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto., Maryland
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore, Maryland
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1415 Argyle Avenue
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Eugee Raymond
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie Lofland
19a. INFORMANT'S NAME (Type/Print): Allen Burris
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1724 Windemere Rd. Balto., Md. 21218
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery
20c. LOCATION — City or Town, State: Landsdowne Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Derrick C. Jones
22. NAME AND ADDRESS OF FACILITY: Derrick Jones F.H. 4611 Park Heights Avenue 21215

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alcohol Abuse

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. [illegible] (Street and Number or Rural Route Number, Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lawrence Kass
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 09/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lawrence Kass MD U of Md Hosp
31. DATE FILED (Month, Day, Year): SEP 20 1989
32. REGISTRAR'S SIGNATURE: Gina DeWilson-Randall

DHMH-16 Rev 1/89

89 25683

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John Shipley | | | 2. DATE OF DEATH (Month, Day, Year): 9-17-89 | 3. TIME OF DEATH: 7:00AM M |
| 4. SOCIAL SECURITY NUMBER: 214-44-8257 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-20-1945 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): 601 George Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1641 N. Monroe Street | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): William Shipley | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Janette Jackson | |
| 19a. INFORMANT'S NAME (Type/Print): Joyce Shipley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1641 N. Monroe. Baltimore, Md 21217 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park | 20c. LOCATION — City or Town, State: Randallstown, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Ebron | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify) scene |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Maynie Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25684

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIN SHEPPARD | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 26, 1989 | 3. TIME OF DEATH: 9:15 A M |
| 4. SOCIAL SECURITY NUMBER: 173-18-4679A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 20, 1906 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 7894 Stonehearth Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Severn | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severn | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7894 Stonehearth Rd. | | 10f. ZIP CODE: 21144 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeepper | | 16b. KIND OF BUSINESS/INDUSTRY: Hospital for the Aged |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Sheppard | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1805 Hays St., Carnegie, PA 15106 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jefferson Memorial Park | | 20c. LOCATION — City or Town, State: South Park Twnp. PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg | | 22. NAME AND ADDRESS OF FACILITY: ROB ERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO-PULMONARY ARREST. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CHOLANGIO CARCINOMA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Randby MD | 29c. LICENSE NUMBER: D14364 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-20-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 14201 Laurel Park Drive # 100, Laurel, Md. 20707 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25685

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Clarence Smith | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 14 89 | 3. TIME OF DEATH: 1044p M |
| 4. SOCIAL SECURITY NUMBER: 214-26-0194 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 17, 1930 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | 9c. COUNTY OF DEATH: Prince George's | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? XX YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 3815 Chatham Road | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Florist self employed | 16b. KIND OF BUSINESS/INDUSTRY: Florist | |
| 17. FATHER'S NAME (First, Middle, Last): George James | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille James | | |
| 19a. INFORMANT'S NAME (Type/Print): Jeannette ,M Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3815 Chatham Road Baltimore, Maryland 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlutus Memorial Park | 20c. LOCATION — City or Town, State: Baltimore County, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herbert E. Nutter | | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial Dis.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic Myocardial Dis.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| X YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| X 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Carl Rogers M.D. | D09975 | Sept. 14 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Knudsen-Randall |

DHMH-16 Rev 1/89

89 25686

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JESSE SEIDMAN | | | 2. DATE OF DEATH (Month, Day, Year): September 17, 1989 | 3. TIME OF DEATH: 10:00 P. M |
| 4. SOCIAL SECURITY NUMBER: 215-12-8632 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 25, 1908 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 6722 25th Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville | | 9c. COUNTY OF DEATH: Prince George's |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Hyattsville | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6722 25th Avenue | | 10f. ZIP CODE: 20782 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1941 thru 1946 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Merchant | 16b. KIND OF BUSINESS/INDUSTRY: Grocery | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Seidman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Jeff | |
| 19a. INFORMANT'S NAME (Type/Print): Gertrude Seidman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6722 25th Avenue, Hyattsville, Maryland 20782 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Lebanon Cemetery | 20c. LOCATION — City or Town, State: Adelphi, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein | | 22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | dilated cardiomyopathy | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | atherosclerosis | 40 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: chronic renal failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 6 [X] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mark S Rosen MD | 29c. LICENSE NUMBER: D20400 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mark S Rosen MD 3441 FERRARA DRIVE WHEATON, MARYLAND 20906 Silver Spring, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leonard (LEONARD STEINHORN) STEINHORN | | | 2. DATE OF DEATH: MONTH 09 DAY 14 YEAR 89 | 3. TIME OF DEATH: 8:50 A M |
| 4. SOCIAL SECURITY NUMBER: 218 07 4122 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1 2 18 | 8. BIRTHPLACE (State or Foreign Country): XXXXX |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3808 MIDHEIGHTS RD | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN | 16b. KIND OF BUSINESS/INDUSTRY: RETAIL | |
| 17. FATHER'S NAME (First, Middle, Last): BENJAMIN STEINHORN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. GERTRUDE STEINHORN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 MIDHEIGHTS RD BALTO.,MD 21215 | |
| 20a. METHOD OF DISPOSITION: X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PROGRESSIVE RUDOMER VEREIN | 20c. LOCATION — City or Town, State: ROSEDALE,MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CANCER OF ESOPHAGUS & STOMACH

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William L Yap MD | 29c. LICENSE NUMBER: D31256 | 29d. DATE SIGNED (Month, Day, Year): 9/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM L. YAP MD BALTIMORE COUNTY GEN HOSPITAL

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Githa Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JESSIE SUTTLEMAN / JESSIE SUTTLEMAN | | | 2. DATE OF DEATH (Month, Day, Year) 9-14-89 | 3. TIME OF DEATH 2:00 PM |
| 4. SOCIAL SECURITY NUMBER 214-20-0134 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year) 12-24-1903 | 8. BIRTHPLACE (State or Foreign Country) RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 3600 LABYRINTH RD. | | 10f. ZIP CODE 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6 College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB NOAH ZEMIL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FEIGA CHAYA WOLLOCH | |
| 19a. INFORMANT'S NAME (Type/Print) EUGENE SUTTLEMAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23351 CHAGRIN BLVD. BEACHWOOD, OHIO 44122 | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETH TFILOH CEMETERY | 20c. LOCATION — City or Town, State BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Gilmore Levinson | | 22. NAME AND ADDRESS OF FACILITY SOL LEIVNSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMONIA — 2 DAYS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END-STAGE DEMENTIA

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) — | 28b. TIME OF INJURY — M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED — |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) — |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER A Lucio, MD ATTENDING MD | 29c. LICENSE NUMBER D30951 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-14-89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2434 W. BELVEDERE AVE BALTO 21215-5296 | | | |
| 31. DATE FILED (Month, Day, Year) SEP 21 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sklar, Melvin — MELVIN M. SKLAR | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 18 / 89 | 3. TIME OF DEATH: 08 A M |
| 4. SOCIAL SECURITY NUMBER: 216-07-1708 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/5/10 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSP of BALTO | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO, MD | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1713 REGENT RD. | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: PAINT MFG. |
| 17. FATHER'S NAME (First, Middle, Last): BARNETT SKLAR | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BEATRICE RABKIN | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. THELMA SKLAR | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 REGENT RD. BALTO., MD 21209 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW | 20c. LOCATION — City or Town, State: REISTERSTOWN, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PROBABLE MYOCARDIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC HEART DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DIABETES MELLITUS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. SUPRANUCLEAR PALSY. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Patricia A. Snello M.D. | 29c. LICENSE NUMBER: D22647 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-18-89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICIA A. SNELLO, M.D. SINAI HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): JAKE STEIN
2. DATE OF DEATN: MONTH SEPT 14, DAY 1989 YEAR
3. TIME OF DEATN: 6:05 PM M
4. SOCIAL SECURITY NUMBER: 216-32-6496
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTN (Month, Day, Year): MAR 25, 1901
8. BIRTHPLACE (State or Foreign Country): RUSSIA
9a. FACILITY NAME (If not institution, give street and number): 6022 WOODCREST AVE
9b. CITY, TOWN OR LOCATION OF DEATN: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6022 WOODCREST AVE
10f. ZIP CODE: 21209
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married XX Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 XX NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: XXX
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BROKER
16b. KIND OF BUSINESS/INDUSTRY: FRUIT & PRODUCE
17. FATHER'S NAME (First, Middle, Last): MAX STEIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA LEVINSON
19a. INFORMANT'S NAME (Type/Print): MRS. HYMAN HARANSKY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6022 WOODCREST AVE BALTO., MD 21209
20a. METHOD OF DISPOSITION: X [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO CEMETERY
20c. LOCATION — City or Town, State: BALTO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allenson Levinson
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arreat, ahock, or heart feilure. List only ons cause on eech lins. — Approximets Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) → a. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if sny, leading to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATN (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: SEYMOUR H. RUBIN M.D
29c. LICENSE NUMBER: D10187
29d. DATE SIGNED (Month, Day, Year): ▶ 9/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 711 PARK HEIGHTS AVE, BALTIMORE, MD 21215
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Gale Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans. permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET M. SULLIVAN
2. DATE OF DEATH (Month, Day, Year): SEPT. 17, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 224-06-0161
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAR. 01, 1899
8. BIRTHPLACE (State or Foreign Country): INDIANA
9a. FACILITY NAME (If not institution, give street and number): 2323 KILLORAN RD.
9b. CITY, TOWN OR LOCATION OF DEATH: TIMONIUM
9c. COUNTY OF DEATH: BALTO. CO.

**RESIDENCE OF DECEDENT**

10a. STATE: MARYLAND
10b. COUNTY: BALTO. CO.
10c. CITY, TOWN OR LOCATION: TIMONIUM
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 2323 KILLORAN RD.
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — ~~American Indian~~, Black, White, ~~etc~~: Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): JAMES GALLEN
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ANN CASEY
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FAIRFAX MEMORIAL
20c. LOCATION — City or Town, State: FAIRFAX, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey L. Gair
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2325 YORK RD. TIMONIUM, MD.

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CORONARY ARTERY DISEASE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | CORONARY ATHEROSCLEROSIS | 2½ |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | CONGESTIVE HEART FAILURE | 1 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald O. Wood MD
29c. LICENSE NUMBER: D11174
29d. DATE SIGNED (Month, Day, Year): ▶ 10/88
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD O. WOOD, MD 2 GREENMEADOW DRIVE TIMONIUM MD
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: John Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ORVILLE TAYLOR | | | 2. DATE OF DEATH (Month, Day, Year): 9- 20- 89 | 3. TIME OF DEATH: 7.35 A M |
| 4. SOCIAL SECURITY NUMBER: 401-24-1628 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 2-7-1923 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): 224 Baltimore Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk, MD. 21222 | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 224 Baltimore Ave. | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker | 16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Whitney Taylor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ALice Hacker | |
| 19a. INFORMANT'S NAME (Type/Print): Emma Taylor | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 Baltimore,Ave.Dundalk,MD.21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans | 20c. LOCATION — City or Town, State: Owings Mills,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Starks Jr | | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral HOme,Inc. 2134 Willow Spring Rd.Dundalk,Md.21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Prostate cancer | 3yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| M. Purlee MD | D-19714 | ▶ 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary T. Vodusek | | | 2. DATE OF DEATH (Month, Day, Year): 09-16-89 | 3. TIME OF DEATH: 4:45 M |
| 4. SOCIAL SECURITY NUMBER: 220-44-8046 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 09-26-1897 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1801 Wentworth Rd. | | 10f. ZIP CODE: 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): WENCESLAUS KOSAR | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA | | |
| 19a. INFORMANT'S NAME (Type/Print): Meridian Nursing Home | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as above | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEM. | | 20c. LOCATION — City or Town, State: PARKVILLE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey F. Gaie | | 22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL 3800 HAROLD RD. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Shock.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Peritonitis.

DUE TO (OR AS A CONSEQUENCE OF):

c. Ruptured Peritoneum.

DUE TO (OR AS A CONSEQUENCE OF):

d. Perforated Abdominal Viscus.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer Disease.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: F. A. Bourgeois MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9/16/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): F. A. Bourgeois MD. 7491 Osler Drive Towson MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): 9/SEP/21/1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Louise Taylor Watson | | | | 2. DATE OF DEATH: MONTH 9 DAY 19 YEAR 89 | 3. TIME OF DEATH: 8:40 A M |
| 4. SOCIAL SECURITY NUMBER: 219-42-7787 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11/10/10 | 9. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Berlin Nursing Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Berlin | | 9c. COUNTY OF DEATH: Worcester |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Worcester | | 10c. CITY, TOWN OR LOCATION: Berlin | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 3, Box 542 | | | 10f. ZIP CODE: 21811 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): 1 yr. | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Harry Francis Taylor | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Holland | | |
| 19a. INFORMANT'S NAME (Type/Print): Maurice Elwood Watson | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3, Box 542 Berlin, MD 21811 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | | 20c. LOCATION — City or Town, State: Berlin, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H. Fisk Burbage | | | 22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home 108 Williams St. Berlin, MD 21811 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | 4 Days. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Age | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Lymphocitic Lymphoma

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D 02026 | ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FEDERICO G. ARTHES, MD.. #3 BAY ST., BERLIN, MD 21811

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25639

89 25695

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH (Month / Day / Year) | | 3. TIME OF DEATH |
| [redacted] BEULAH B. WARD | | | | 9 / 17 / 89 | | 8:45 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) |
| 219-46-4822-T | 1 ☐ M 2 ☒ F | 93 YRS. | | 8/3/1896 | | Crisfield, MD |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | | |
| ALICE BYRD TAWES NURSING HOME | | Crisfield, MD | | Somerset | | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | |
| Maryland | Somerset | Crisfield, MD | | 1 ☒ YES 2 ☐ NO | | |
| 10e. STREET AND NUMBER | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| 138 Maryland Avenue | | 21817 | | U.S.A. | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | 14. RACE — American Indian, Black, White, etc. | | |
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | | Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| Elementary/Secondary (0-12): H. S. Graduate — College (1-4 or 5+): | | Secretary | | Fishing Industry | | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | |
| William A. Burke | | Annie Somers | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | |
| Marian Nelson | | 110 Mariners Rd. - Crisfield, MD 21817 | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | |
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | Crisfield Cemetery | | Crisfield, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Robert H. Bradshaw | | 22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home, 306 W. Main St., Crisfield, Maryland 21817 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Cardiomyopathy | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Arteriosclerotic Cardiovascular Disease | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James A. Sterling, MD | D10214 | ▶ 9/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Sterling, M. D. - 320 W. Main St. - Crisfield, MD 21817

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25696

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSEMARY LOUISE WEBLEY | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 15 / 89 | 3. TIME OF DEATH: 08:53 A.M |
| 4. SOCIAL SECURITY NUMBER: 225-05-3816-B | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-8-18 | 8. BIRTHPLACE (State or Foreign Country): Davis, WVA |
| 9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown | | 9c. COUNTY OF DEATH: St. Mary's |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: St. Mary's | 10c. CITY, TOWN OR LOCATION: Piney Point | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: P.O. Box 189 Beach Road | | 10f. ZIP CODE: 20674 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home-maker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Dorie C. Lear | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Ethel Junkins | | |
| 19a. INFORMANT'S NAME (Type/Print): Howard B. Webley (Husbnad) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 189, Beach Road, Piney Point, MD 20674 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sterling Cemetery | 20c. LOCATION — City or Town, State: Sterling, Virginia | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. Burkley Green | 22. NAME AND ADDRESS OF FACILITY: Green Funeral Home 721 Elden Street, Herndon, VA 22070 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Failure | hrs |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Cerebral Cancer, Glioblastoma | months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Patrick Jarboe M.D.

29c. LICENSE NUMBER: D0641 9(MD

29d. DATE SIGNED (Month, Day, Year): ▶ 9-15-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): SEP 21 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25697

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDITH B. WITTSTADT | | | 2. DATE OF DEATH Month: 9 Day: 17 Year: 89 | 3. TIME OF DEATH: 2103 M |
| 4. SOCIAL SECURITY NUMBER: 430-20-8688 | 5. SEX: 1 ☐ M 2 ☒ F | 5. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-15-21 | 8. BIRTHPLACE (State or Foreign Country): KENTUCKY |
| 9a. FACILITY NAME (If not institution, give street and number): St Joseph Hospital, Towson, MD | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: BALTO |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: BALTO | 10c. CITY, TOWN OR LOCATION: BALTO | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2510 WYCLIFFE AVE | | 10f. ZIP CODE: 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OFFICE ASSISTANT | | 16b. KIND OF BUSINESS/INDUSTRY: ASSOC CHILDRENS THEATER |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL BLEVINS | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LUSINA WILLIAMSON | |
| 19a. INFORMANT'S NAME (Type/Print): SANDRA W. SPENCE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2113 FOLKSTONE RD., TIMONIUM, MD. 21093 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT | | 20c. LOCATION — City or Town, State: BALTO. CITY, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Frances C. Evans | | 22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2625 YORK RD., TIMONIUM | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Insufficiency

DUE TO (OR AS A CONSEQUENCE OF): b. Severe Emphysema

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Acute Hemorrhage into right pleural Cavity 2° to CPR

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D0234 | ▶ 9/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL CH. LEE, M.D. ST. JO. HOSP. TOWSON MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25698

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAURINE WILLIAMS | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 14, 1989 | 3. TIME OF DEATH: 7:06P M |
| 4. SOCIAL SECURITY NUMBER: 219-28-8536 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-1-33 |
| 8. BIRTHPLACE (State or Foreign Country): Arkansar | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Columbia | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10786 GreenMountain Circle | | 10f. ZIP CODE: 21044 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Records Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Banking Industry |
| 17. FATHER'S NAME (First, Middle, Last): | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Macon | |
| 19a. INFORMANT'S NAME (Type/Print): Cornell Clash | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 63 Midline Court Gaithersburg Md. 20879 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Maryland Vet. | 20c. LOCATION — City or Town, State: Crownsville Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones | | 22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Avenue 21215 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatic failure | 2 wks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Ovarian Carcinoma to liver | 3 1/2 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D | 29c. LICENSE NUMBER: D38201 | 29d. DATE SIGNED (Month, Day, Year): 9/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy J. MAYNIHAN M.D. 600 No. Wolfe St, Balt. Md 21205 | | |
| 31. DATE FILED (Month, Day, Year): SEP 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ki Se YI | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 18 1989 | 3. TIME OF DEATH: 1:55 P M |
| 4. SOCIAL SECURITY NUMBER: 227-96-2964 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04-16-1915 | 8. BIRTHPLACE (State or Foreign Country): KOREA |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSP. | | 9b. CITY, TOWN OR LOCATION OF DEATH: ROSEDALE | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CO | 10c. CITY, TOWN OR LOCATION: ESSEX | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 8 HORSE CHESTNUT CT. | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: KOREAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMER | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): BONG RO YI | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): TAE H. HONG | |
| 19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEM. | 20c. LOCATION — City or Town, State: COCKEYSVILLE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2325 YORK RD. TIMONIUM | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Chronic Obstructive Pulmonary Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Seizure Disorder | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Melanie J Marshall DO | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-18-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Melanie J. Marshall D.O. 9000 Franklin Sq. Dr. Baltimore 21237 | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: Jeha Davidson-Randall | |

DHMH-18 Rev 1/89

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Items:28a thru 28f per ME G-656
10-18-89 cm

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Dietrick | Michelle | Anderson | 9 / 17 / 89 | 12:50 pM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-89-0834 | 1 ☐ M 2 ☒ F | 26 YRS. | | | 7-7-63 | S.C. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 2208 E Lanvale St. | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2208 EAST LANVALE STREET | 21213 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO | BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| UNKNOWN | | UNEMPLOYED | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| ERNEST ANDERSON | ARLENE CROMER |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARION FERGUSON | 1429 MYRTLE AVENUE/BALTIMORE, MARYLAND 21217 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MOUNT ZION CEMETERY | LANSDOWNEL, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Calvin L. Williams | WM. C. MARCH F.H. 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Strangulation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 9-14-89 | M | 1 ☐ YES 2 ☒ NO | Subject Strangled |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Home | 2208 E. Lanvale St. Baltimore City, Maryland |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Chas P. Kokes MD | OCME | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. 111 Penn St. Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joe L. Askew
2. DATE OF DEATH — MONTH: 9 DAY: 20 YEAR: 89
3. TIME OF DEATH: 335 AM
4. SOCIAL SECURITY NUMBER: 242 58 5914
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 53 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-16-36
8. BIRTHPLACE (State or Foreign Country): N.C

9a. FACILITY NAME (If not institution, give street and number): Loch Raven Va Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4720 Wakefield Road
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Diamond Cab. Co.

17. FATHER'S NAME (First, Middle, Last): Frank Askew, Sr
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Howard

19a. INFORMANT'S NAME (Type/Print): Sandra Lee Askew
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4720 Wakefield Rd Apt 204 Balto, Md 21216

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet
20c. LOCATION — City or Town, State: Owings Mills Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lola March
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | immed. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pancreatic Carcinoma | Dx 11/88 10 mo prior to death |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospital

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Debra Becker MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 9-20-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Debra Becker 3900 Loch Raven Blvd Baltimore, MD 21218
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cornelius B. Allmond
2. DATE OF DEATH — MONTH: 09 DAY: 20 YEAR: 89
3. TIME OF DEATH: 6:50 P M
4. SOCIAL SECURITY NUMBER: 230-52-6676
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 46 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-17-43
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2222 Mt Holly St
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Moses Allmond
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Baker
19a. INFORMANT'S NAME (Type/Print): Stephanie Allmond
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2222 Mt Holly St Balto, Md 21216
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jones Grove Bapt Ch
20c. LOCATION — City or Town, State: Windsor, Va
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such as cardisc or respiratory arreet, ahock, or heert failure. List only ona ceuse on each line.

| | | Approximate Interval Between Onset and Dasth |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in desth) → a. | Metastatic non-small cell carcinoma of the lung | 6 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST — b. | Atherosclerotic coronary heart disease | 8 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Persistent hematuria | 2 weeks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other signiticent conditions contributing to desth but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Melba J Beine MD
29c. LICENSE NUMBER: D35740
29d. DATE SIGNED (Month, Day, Year): 9.20.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Melba Beine MD 333 St. Paul Place Baltimore MD 21202
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25703

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET ALVERTA ACKERMAN | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 219-38-8560 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-9-1915 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 104 HILLSIDE ROAD | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: FLORIDA | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: FORT MEYER BEACH | 10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 19281 SAN CARLOS BLVD | 10f. ZIP CODE: 33931 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGH SCHOOL; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM TILDEN STOCKSDALE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE C. BELT | | |
| 19a. INFORMANT'S NAME (Type/Print): GEORGE F. ACKERMAN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 HILLSIDE ROAD BALTIMORE, MARYLAND 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK 9-21-89 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott P. Gardner | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PULMONARY INSUFFICIENCY
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald Goodnull M.D

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): 9-20-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JHH Hoeck 2418 Balto. Md 21205

31. DATE FILED (Month, Day, Year): SEP 22 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 25704

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS BLUE SR. | | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 18 / 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 240-20-0825 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-17-23 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 2018 CLIFTWOOD AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER: 2018 CLIFTWOOD AVENUE | | 10f. ZIP CODE: 21213 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES: NAVY | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S. POST OFFICE | | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): VANDYKE BLUE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GEORGIANA SPELLMAN BLUE | | | |
| 19a. INFORMANT'S NAME (Type/Print): DOLLIE MAE BLUE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2018 CLIFTWOOD AVENUE/BALTIMORE, MARYLAND 21213 | | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND NAT'L MEM. PK. CEM. | | 20c. LOCATION — City or Town, State: LAUREL CO., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Theresa Davis | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F.H. 1101 E. NORTH AVENUE 21202 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma OF The Prostate c metastases Liver | 1 Month |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma OF The prostate — | 1 Year |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |
|---|---|

| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Eugene H. Owens MD | DI 2601 | 9-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eugene H. Owens MD 1735 E. Federal St Balto, Md 21213

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25705

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WINNIE JASPER BRIDGES JR. | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 18 1989 | 3. TIME OF DEATH: 1630 PM |
| 4. SOCIAL SECURITY NUMBER: 426-78-1581 | 5. SEX: 1 [ ] M 2 [X] F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): SEP 23 1918 | 8. BIRTHPLACE (State or Foreign Country): MISSISSIPPI |
| 9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA | | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: VIRGINIA | 10b. COUNTY: PRINCE WILLIAM | 10c. CITY, TOWN OR LOCATION: WOODBRIDGE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 16001 CREST DRIVE | | 10f. ZIP CODE: 22191 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1937 - 1959 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CIVIL SERVANT | 16b. KIND OF BUSINESS/INDUSTRY: PROCUREMENT OFFICER |
| 17. FATHER'S NAME (First, Middle, Last): WINNIE JASPER BRIDGES SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LORENE SALLIE BOYD | |
| 19a. INFORMANT'S NAME (Type/Print): NANCY C. BRIDGES | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16001 CREST DRIVE, WOODBRIDGE, VA 22191 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): QUANTICO NATIONAL CEMETERY | 20c. LOCATION — City or Town, State: QUANTICO, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ B. Earl Mountcastle | | 22. NAME AND ADDRESS OF FACILITY: Mountcastle Funeral Home 4143 Dale Boulevard Dale City, VA 22193 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: W. L. Dahut MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ SEPT 19 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W. L. DAHUT, LT, MC, USN | NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20814-5011 | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gene Burden-Kendall | |

DHMH-18 Rev 1/89

89 25706

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY VIRGINIA BURRELL | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: 6:20 a M |
| 4. SOCIAL SECURITY NUMBER: 578-34-2644 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-25-27 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): NIH, THE CLINICAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA, MARYLAND | 9c. COUNTY OF DEATH: MONTGOMERY | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: District | 10b. COUNTY: of Columbia | 10c. CITY, TOWN OR LOCATION: WASHINGTON, DC | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4928 B STREET SE, | 10f. ZIP CODE: 20019 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last): Michael Estep | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virgie McKee | | |
| 19a. INFORMANT'S NAME (Type/Print): MR. CARL BURRELL | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4928 B STREET SE. WASHINGTON, DC 20019 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | 20c. LOCATION — City or Town, State: Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John T. Stewart, III | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd., N.E. Wash. D.C,. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Colon Carcinoma | months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Broncho Pneumonia | days |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Angelo Russo MD | 29c. LICENSE NUMBER: 0101035937 | 29d. DATE SIGNED (Month, Day, Year) ▶ 09-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANGELO RUSSO 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25707

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas Blander | | | 2. DATE OF DEATH (Month, Day, Year): September 8, 1989 | 3. TIME OF DEATH: 2:10P M |
| 4. SOCIAL SECURITY NUMBER: 246-42-8127 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/22/32 | 8. BIRTHPLACE (State or Foreign Country): S. CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | |
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald M Chase 9-20-89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anoxic Encephalopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): Squamous cell Carcinoma of the hypopharynx | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol abuse
History of Tuberculosis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rita Abbud | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rita Abbud, M.D. c/o Maryland General Hsopital | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-18 Rev 1/89

89 25708

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jack F Bordine
2. DATE OF DEATH (Month, Day, Year): 09 18 89
3. TIME OF DEATH: 0654 M
4. SOCIAL SECURITY NUMBER: 385-10-2414
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/15/1915
8. BIRTHPLACE (State or Foreign Country): MICH.
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: BALTO CITY
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1641 EASTERN AVE
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MACHINIST
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): CLAYTON BORDINE
18. MOTHER'S NAME (First, Middle, Maiden Surname): LAURA HAVEN
19a. INFORMANT'S NAME (Type/Print): GIRARD BORDINE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT 1 - BOX 102 EVANS LA
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAKLAWN
20c. LOCATION — City or Town, State: BALTO
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward J Weber
22. NAME AND ADDRESS OF FACILITY: EDWARD J. WEBER 401 S CHESTER ST

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ~~Sepsis (Bacteremia)~~ Cardiac Shock — 5 hours
DUE TO (OR AS A CONSEQUENCE OF): Sepsis (Bacteremia)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Dis
Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Wagner MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 9-18-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 22 S Greene St Balt, MD 21201

31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 25709

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CROUNSE, MILDRED MAY CROUNSE | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 20, 1989 | 3. TIME OF DEATH: 10 45 A.M |
| 4. SOCIAL SECURITY NUMBER: 213-18-6747 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 20, 1923 |
| 8. BIRTHPLACE (State or Foreign Country): OHIO | | | |
| 9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON | 9c. COUNTY OF DEATH: HARFORD | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: HARFORD | 10c. CITY, TOWN OR LOCATION: JOPPA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 507 MAGNOLIA ROAD | 10f. ZIP CODE: 21085 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN M. HUTCHINSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CHRISTINA A. KOSCEILSKI | | |
| 19a. INFORMANT'S NAME (Type/Print): RAYMOND CROUNSE (HUSBAND) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 MAGNOLIA ROAD, JOPPA, MARYLAND 21085 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HIGHVIEW MEMORIAL PARK | 20c. LOCATION — City or Town, State: FALLSTON, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dennis A Capitano | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ANOXIC ENCEPHALOPATHY | 1 WK |
| | DUE TO (OR AS A CONSEQUENCE OF): CARDIAC ARREST | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SMALL CELL LUNG CANCER

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): JOHN P. EISNER 9705 BELAIR RD MD 21047 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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89 25710

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Gordon Collins Sr. | | | 2. DATE OF DEATH (Month, Day, Year): 9-20-89 | 3. TIME OF DEATH: 12:30AM M |
| 4. SOCIAL SECURITY NUMBER: 215-22-8915 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 24, 1927 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): 4923 E. Chase Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 4923 E. Chase Street | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 8+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Body Maker | 16b. KIND OF BUSINESS/INDUSTRY: Can Co. | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Oakley Clyde Collins | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eugenia B. Blake |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth M. Collins | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4923 E. Chase Street, Balto., Md. 21205 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Collins | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home XX Residence 8 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one) ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-20-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. KOkes, M.D. 111 Penn Street, baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Jacki Davidson-Randall | |

DHMH-16 Rev 1/89

89 25711

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN C CARNEY
2. DATE OF DEATH: MONTH 9 DAY 14 YEAR 89
3. TIME OF DEATH: 720 PM
4. SOCIAL SECURITY NUMBER: 217-26-3242
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/21/21
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 5005 LIBERTY HEIGHTS AVE.
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname):
19a. INFORMANT'S NAME (Type/Print):
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Samuel N Wade 9-21-89
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARCINOMA LUNG WITH BRAIN
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. METASTASIS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sher A Hashmi MD
29c. LICENSE NUMBER: D24648
29d. DATE SIGNED (Month, Day, Year): 9-14-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHER HASHMI 2600 LIBERTY HEIGHTS AVE 21215
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Gene Burdette-Mendez

DHMH-18 Rev 1/89

89 25712

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET E. CHRISTIAN | | | 2. DATE OF DEATH: MONTH 9 DAY 16 YEAR 89 | 3. TIME OF DEATH: 6:50 A M |
| 4. SOCIAL SECURITY NUMBER: 218-22-7276 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-12-1897 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: TOWSON | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4101½ OLD YORK ROAD | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: WORKSHOP FOR THE BLIND | |
| 17. FATNER'S NAME (First, Middle, Last): | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): | |
| 19a. INFORMANT'S NAME (Type/Print): HELEN GILNER | | 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 226½ Cleveland Ave., Baltimore, Md. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony Bowden | 22. NAME AND ADDRESS OF FACILITY: 655 W. Dult. St. STATE ANATOMY BOARD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CEREBRAL VASCULAR ACCIDENT
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carla S. Alexander M.D. | 29c. LICENSE NUMBER: D27087 | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: |

DNMN-16 Rev 1/89

89 2715

89 25713

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian Mae Draughn | | | 2. DATE OF DEATH (Month, Day, Year): 9 20 89 | | 3. TIME OF DEATH: 5:10 AM |
| 4. SOCIAL SECURITY NUMBER: 242-60-5984 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 49 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-5-40 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Deaton Hospital + Med Ctr | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD | | | 9c. COUNTY OF DEATH: Baltimore City | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ===== | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2019 Wilhelm Street | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home Maker | |
| 17. FATHER'S NAME (First, Middle, Last): Clyde A. Collins | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amanda J. Pegram | |
| 19a. INFORMANT'S NAME (Type/Print): Evelyn R. Jones | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2019 Wilhelm Street Baltimore, Maryland 21223 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn Park, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donna M Baranowski | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Melanoma | 3 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bone metastases & pathologic fxs; Smoking; Decubitus Ulcer

| | |
|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy J. Kearney M.D. | 29c. LICENSE NUMBER: D37458 | 29d. DATE SIGNED (Month, Day, Year): 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25714

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT BRUCE DUNWIDDIE | | | 2. DATE OF DEATH (Month, Day, Year): 9 19 89 | 3. TIME OF DEATH: 1:00 P.M. M |
| 4. SOCIAL SECURITY NUMBER: 495-12-3480 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9/3/22 | 8. BIRTHPLACE (State or Foreign Country): New Mexico |
| 9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Columbia | | 9c. COUNTY OF DEATH: Howard |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Howard | 10c. CITY, TOWN OR LOCATION: Columbia | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 10600 Spotted Horse Lane | | 10f. ZIP CODE: 21044 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO If YES, GIVE WAR OR DATES: 1942 - 1962 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lt. Col. | | 16b. KIND OF BUSINESS/INDUSTRY: Army |
| 17. FATHER'S NAME (First, Middle, Last): Bruce Rambo Dunwiddie | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Lighton | | |
| 19a. INFORMANT'S NAME (Type/Print): Ronald Dunwiddie | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10600 Spotted Horse Lane Columbia, Md. 21044 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. Shy-Drager's Syndrome | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William Flowers MD | D20708 | ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Flowers MD 11055 Little Patuxent Columbia Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25715

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert H. Evans
2. DATE OF DEATH: MONTH 09 DAY 19 YEAR 89
3. TIME OF DEATH: 735 P M
4. SOCIAL SECURITY NUMBER: 220 244 266
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07 31 28
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): HARBOR Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: ======

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ======
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 807 Stoll Street
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Roofer
16b. KIND OF BUSINESS/INDUSTRY: General Contractor

17. FATHER'S NAME (First, Middle, Last): Walter Evans
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Overbey

19a. INFORMANT'S NAME (Type/Print): Jean Allman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 Stoll Street Baltimore, Maryland 21225

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
20c. LOCATION — City or Town, State: Glen Burnie, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donna M Bowersox
22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Adeno Ca of Lung c adrenal mets | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Malnutrition 2° (b) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HTN
COPD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Tremarelli - House Physician
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 9-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): 3001 So. Hanover St. Baltimore Md 21230 J. TREMARELLI

31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25716

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Girl Escumbrise Twin "A"
2. DATE OF DEATH: MONTH 9 DAY 14 YEAR 89
3. TIME OF DEATH: 11:44 AM
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): New-born YRS. | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS 0 | MIN. 40
7. DATE OF BIRTH (Month, Day, Year): 9/14/89
8. BIRTHPLACE (State or Foreign Country): Baltimore
9a. FACILITY NAME (If not institution, give street and number): St Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER:
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Rodney Walker
18. MOTHER'S NAME (First, Middle, Maiden Surname): Venus Escumbrise Walker
19a. INFORMANT'S NAME (Type/Print): Rodney Walker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5721 Belle Grove Rd Apt H2 21225
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Hill Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell B. Ober
22. NAME AND ADDRESS OF FACILITY: Ober & Sons Funeral Home 1631 Druid Hill Ave. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme prematurity
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY — M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. Sreedhar MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. SREEDHAR M.D. 8606 OPEN MEADOW WAY. COLUMBIA, MD 21045

31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25717

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Girl Escumbise Twin "B"
2. DATE OF DEATH — MONTH: 9 DAY: 14 YEAR: 89
3. TIME OF DEATH: 12:32 P M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs/last birthday): New born YRS. IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: 8 MIN.: 25
7. DATE OF BIRTH (Month, Day, Year): 9/14/89
8. BIRTHPLACE (State or Foreign Country): Baltimore
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: BA

RESIDENCE OF DECEDENT

10a. STATE:
10b. COUNTY:
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER:
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Rodney Walker
18. MOTHER'S NAME (First, Middle, Maiden Surname): Venus Escumbise Walker
19a. INFORMANT'S NAME (Type/Print): Rodney Walker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 572 Bella Grove Rd Bel Air MD 21225
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fair Hill Cemetery
20c. LOCATION — City or Town, State: Fallston MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Murrell L Eden
22. NAME AND ADDRESS OF FACILITY: Eden Funeral Home 1631 Druid Hill Ave. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme Prematurity
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. Sreedhar MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. SREEDHAR, 8606, OPEN MEADOW WAY, COLUMBIA, MD-21045

31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25718

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EARL D. ELLIS | | | 2. DATE OF DEATH: MONTH 9 DAY 20 YEAR 89 | 3. TIME OF DEATH: 4:45 PM |
| 4. SOCIAL SECURITY NUMBER: 212-05-8116 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/12/16 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5538 Ashbourne Road | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4 or 5 +): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Aerospace Technician | | 16b. KIND OF BUSINESS/INDUSTRY: NASA |
| 17. FATHER'S NAME (First, Middle, Last): Harry B. Ellis | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude F. Neale | | |
| 19a. INFORMANT'S NAME (Type/Print): Olive H. Ellis | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5538 Ashbourne Rd. Baltimore, Md. 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | 9 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| George E. Wicks III MD | | ▶ 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George E. Wicks III MD St. Agnes Hospital Baltimore, Maryland

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Gisha Davidson-Richardson |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CONLEY HAL FRANKLIN, JR. | | | 2. DATE OF DEATH (Month, Day, Year): 9-15-89 | 3. TIME OF DEATH: 1:30PM M |
| 4. SOCIAL SECURITY NUMBER: 218-48-4815 | 5. SEX: 1 ☐ M 2 ☐ F XX | 6. AGE (In yrs. last birthday): 42 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-16-1947 |
| 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 3226 Old North Point Road | 9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK | 9c. COUNTY OF DEATH: Baltimore Co. | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | 10d. INSIDE CITY LIMITS? 1 ☐ YES XX NO |
| 10e. STREET AND NUMBER: 3226 OLD NORTH POINT ROAD | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WNAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ROUTE SALESMAN | 16b. KIND OF BUSINESS/INDUSTRY: BAKING INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): CONLEY HAL FRANKLIN, SR. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MATOKA L. WRIGHT | | |
| 19a. INFORMANT'S NAME (Type/Print): KATHERINE GAYLE FRANKLIN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3226 OLD NORTH POINT ROAD BALTO, MD 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL 9-19-1989 | 20c. LOCATION — City or Town, State: DORSEY, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Narcotic Intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation XX Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-16-89 |
| 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall | |

DHMN-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): AMELIA A. FERGUSON | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 17, 1989 | 3. TIME OF DEATH: 5:30P M |
| 4. SOCIAL SECURITY NUMBER: 216-18-7063 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 12, 1911 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: -- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3582 DUDLEY AVENUE | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -- | College (1-4 or 5 +): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME |
| 17. FATHER'S NAME (First, Middle, Last): MAX SCHROETER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA LENZ | |
| 19a. INFORMANT'S NAME (Type/Print): HUSBAND STANLEY E. FERGUSON, SR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3582 DUDLEY AVENUE, BALTIMORE, MD. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Collins | | 22. NAME AND ADDRESS OF FACILITY: Schumuck Funeral Home, Inc. 3331 BREHMS LANE BALTIMORE, MARYLAND 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary Artery Disease | 10 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Miguel Karacuschansky | 29c. LICENSE NUMBER: D15462 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 201 E. University Pkwy.
Dr. Miguel Karacuschansky - Union Memorial Hosp, Baltimore, Maryland 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25721

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT C. GILMORE | | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: 10:40 A M |
| 4. SOCIAL SECURITY NUMBER: 214-18-8703 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JUNE 16, 1910 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): KENSINGTON GARDENS NURSING CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: KENSINGTON | | 9c. COUNTY OF DEATH: MONTGOMERY |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD. | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: BETHESDA | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5015 BATTERY LANE #306 | | 10f. ZIP CODE: 20814 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INSURANCE BROKER | | 16b. KIND OF BUSINESS/INDUSTRY: INSURANCE | |
| 17. FATHER'S NAME (First, Middle, Last): ROBERT CAMPBELL GILMORE, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ESTELLE LAWS | |
| 19a. INFORMANT'S NAME (Type/Print): ELGAR S. GILMORE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS # 10 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODSIDE CEMETERY | | 20c. LOCATION — City or Town, State: BRINKLOW, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Muriel H. Barber | | 22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD. 20882 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MYOCARDIAL INFARCTION — 24 days.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CORONARY THROMBOSIS
DUE TO (OR AS A CONSEQUENCE OF):
c. HIGH CHOLESTEROL
DUE TO (OR AS A CONSEQUENCE OF):
d. HYPERTENSION

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BINSWANGER DISEASE.
PRE RENAL AZOTEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Roland Imperial MD | DO 5276 | 9-19-89 2:PM. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Roland Imperial 4977 BATTERY LANE BETHESDA, MD. 20814

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ULAMAE HICKS | | | 2. DATE OF DEATH: MONTH 9 DAY 20 YEAR 89 | 3. TIME OF DEATH: 12:40 P M |
| 4. SOCIAL SECURITY NUMBER: 219-18-8374 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06-5025 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1631 E. 31st STREET | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): FRED D. SMITH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELEANOR STATON SMITH | |
| 19a. INFORMANT'S NAME (Type/Print): JANIS R. HICKS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3213 THE ALAMEDA/BALTIMORE, MARYLAND 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | 22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVENUE 21202 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Neurogenic shock | 4 hrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Anoxic injury | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Cardiac arrest | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Coomes, M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Coomes, M.D. Union Memorial Hosp. 201 E. Univ. Pkwy. Balto. Md. 21218 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25723

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ty A Holt | | | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 20 / 89 | 3. TIME OF DEATH: 1:20 p M |
| 4. SOCIAL SECURITY NUMBER: 213-84-1880 | 5. SEX: XM 2 ☐ F | 6. AGE (In yrs. last birthday): 29 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-13-60 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 6 Clementine Ct 1A | | | 9b. CITY, TOWN OR LOCATION OF DEATH: 21237 | | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3607 Erdman Ave. | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Jack N. Holt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathryn Schreiber | |
| 19a. INFORMANT'S NAME (Type/Print): Donna M. Holt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3607 Erdman Ave. Baltimore, Maryland 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Balto.Co.,Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home,P.A. 8521 Loch Raven Blvd.Towson,MD21204 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Contact Gunshot Wound of Head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX 1 YES 2 ☐ NO HEAD ONLY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX 1 YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-20-89 | 28b. TIME OF INJURY: 1:05p M | 28c. INJURY AT WORK? 1 ☐ YES XX NO | 28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT SELF |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6 Clementine Ct. Balto. Co.,MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-21-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St. Baltimore, MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gusha Davidson-Randall |

DHMH-16 Rev 1/89

89 25724

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| MARY | C. | HANNAHS | Sept. 21, 1989 | 5:00 AM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-14-0656 | 1 ☐ M 2 ☒ F | 92 YRS. | | | 8-1-1897 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Meridian Cromwell N.H. | Parkville | Baltimore Co. |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore Co. | Parkville | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 8410-B Greenway Road | 21234 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 5 Years | ---------- | Button Hole Maker | Tailoring |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Joseph Castrilli | Angela Folio |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Raymond J. Castrilli, Sr. | 212 E. Timonium Road Timonium, Maryland 21093 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Moreland Memorial Park | Balto.Co., Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | William E. Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Acute Bronchitis | 12 hrs. |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ ND | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D 9386 | ▶ Sept 21 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

SAMUEL I. O'MANSKY M.D. 8405A Loch Raven Blvd Baltimore MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | [signature] Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25725

89 25725

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary E. Hawkins / MARY E. HAWKINS | | | | 2. DATE OF DEATH MONTH 09 DAY 17 YEAR 89 | 3. TIME OF DEATH 1:20 A.M |
| 4. SOCIAL SECURITY NUMBER 213327994 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 55 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3/28/34 | 8. BIRTHPLACE (State or Foreign Country) MD |
| 9a. FACILITY NAME (If not institution, give street and number) HHC - Medical ward | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD. | | 9c. COUNTY OF DEATH BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Md | 10b. COUNTY Baltimore | 10c. CITY, TOWN OR LOCATION 2441 Westbort St. BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 2441 Westbort St. BALTIMORE | 10f. ZIP CODE 21230 0000 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) JOHNSON WILLIAM | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Johnson |
| 19a. INFORMANT'S NAME (Type/Print) Ollie Johnson Next of kin | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6818 West Ridge Rd. Balto. Md. 21207 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Auburn Cem. | 20c. LOCATION — City or Town, State Westport, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Cecil A. Estep | 22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ischaemic infarction of Brain ? CRF | 3 mth |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Aspiration pneumonia — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Metabolic Acidosis — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. — DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RHDZ MRSTR., COPD, ETOH Abuse

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Under M Khan Sr Lt Cutlers | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Under M Khan Sr Lt Cutlers HHC. Baltimore | | |
| 31. DATE FILED (Month, Day, Year) SEP 22 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Item:23,27 per ME G-655
9-29-89 cm

89 25726

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eugene Harris | | | 2. DATE OF DEATH (Month, Day, Year): 9/9/89 | 3. TIME OF DEATH: 5:15A M |
| 4. SOCIAL SECURITY NUMBER: 226-36-0054 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/19/34 | 8. BIRTHPLACE (State or Foreign Country): VA. |
| 9a. FACILITY NAME (If not institution, give street and number): 2407 Linden Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2407 LINDEN AVENUE | | 10f. ZIP CODE: | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): ROOSEVELT HARRIS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE PRICE | |
| 19a. INFORMANT'S NAME (Type/Print): BARBARA OLIVER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 66 W. 2nd ST., MT. VERNON, N.Y. 10550 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] 9-20-89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lobar Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D. 111 Penn St., Baltimore, Md. 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Walter W. Holland
2. DATE OF DEATH (Month, Day, Year): 09 16 89
3. TIME OF DEATH: 0230 M
4. SOCIAL SECURITY NUMBER: 218-28-7892
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 54 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-29-35
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 719 E. Cold Spring La. - Balto, Md
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 1963
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factor Worker
16b. KIND OF BUSINESS/INDUSTRY: Opto Instrument
17. FATHER'S NAME (First, Middle, Last): Charles Holland
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Spears
19a. INFORMANT'S NAME (Type/Print): Virginia Weeks
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4005 Edmondson Ave - Balto Md 21229
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Garrison Forest
20c. LOCATION — City or Town, State: Owings Mills Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Henry M. Culmer
22. NAME AND ADDRESS OF FACILITY: Culmer Funeral Service 3605 W. Franklin St. 21229

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aspiration Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. hepatic failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: malnutrition; anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Judith E. Thomas MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Judith Thomas 201 E. University Pkwy Balto MD 21218
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25727

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William H.ubbard Joiner Sr.

2. DATE OF DEATH (Month, Day, Year): Sept. 20, 1989

3. TIME OF DEATH: 12:30 A M

4. SOCIAL SECURITY NUMBER: 215-10-7626

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Sept 23, 1913

8. BIRTHPLACE (State or Foreign Country): Sanford, FLA

9a. FACILITY NAME (If not institution, give street and number): 2507 Lakewood Ct.

9b. CITY, TOWN OR LOCATION OF DEATH: Parkville

9c. COUNTY OF DEATH: Balto. Co.

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY: Balto. Co.

10c. CITY, TOWN OR LOCATION: Parkville

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 2507 Lakewood Ct.

10f. ZIP CODE: 21234

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2 yrs

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Fireman & Engineer

16b. KIND OF BUSINESS/INDUSTRY: Penn. Railroad

17. FATHER'S NAME (First, Middle, Last): Fleetwood Joiner

18. MOTHER'S NAME (First, Middle, Maiden Surname): Eula Wilson

19a. INFORMANT'S NAME (Type/Print): (Wife) Mrs. Jeanette Joiner

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory

20c. LOCATION — City or Town, State: Catonsville, MD

21. SIGNATURE OF FUNERAL SERVICES LICENSEE: ▶ [signature]

22. NAME AND ADDRESS OF FACILITY: Charlton Funeral Home, 2007 Eastern Ave, Balto., MD 21231

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myelodysplastic (Sideroblastic) Anemia — 10 years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cardiac Dysrhythmia 3rd Degree AV Block

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles E Shaw MD

29c. LICENSE NUMBER: D10129

29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles E. SHAW, M.D., 607 W. Joppa Road, Towson Md. 21204

31. DATE FILED (Month, Day, Year): SEP 22 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25729

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Emily B. Jones | | | | | 2. DATE OF DEATH (Month, Day, Year): 9 / 19 / 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 220-22-7784 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-14-1921 | 8. BIRTHPLACE (State or Foreign Country): Va |
| 9a. FACILITY NAME (If not institution, give street and number): 5107 Sunset Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5107 Sunset Road | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Leroy E. Ball | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances E. Curry |
| 19a. INFORMANT'S NAME (Type/Print): James Jones | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5107 Sunset Road Baltimore, Md 21215 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lola March | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SUDDEN DEATH 2° to POSS. VENT. RICULAR TACHYcardia
DUE TO (OR AS A CONSEQUENCE OF):
b. COR PULMONALE / COPD
DUE TO (OR AS A CONSEQUENCE OF):
c. HTN, ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
A/P CHF, LVH
PNEUMONECTOMY (L)

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A. Enrique MD | 29c. LICENSE NUMBER: D14829 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. C. ENRIQUE MD 2435 W. BELVEDERE, BALTO MD 21215

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25730 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert E. Jones
2. DATE OF DEATH (Month, Day, Year): 9-16-89
3. TIME OF DEATH: 1:50PM M
4. SOCIAL SECURITY NUMBER: 219-50-0196
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 40 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 8/20/49
8. BIRTHPLACE (State or Foreign Country): S. CAROLINA
9a. FACILITY NAME (If not institution, give street and number): Construction site/Timber Trails Ct.
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: Howard County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2923 RIDGEWOOD AVENUE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY: PLUMBING
17. FATHER'S NAME (First, Middle, Last): ROBERT L. JONES
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANABELLE JONES HILL
19a. INFORMANT'S NAME (Type/Print): DEBORAH JONES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2923 RIDGEWOOD AVENUE: BALTO, MD. 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. AUBURN CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett
22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Compressional Asphyxia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify) Scene
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 9-15-89
28b. TIME OF INJURY: 3:00PM
28c. INJURY AT WORK? 1 [X] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: Ditch caved in on subject
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): worksite
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Construction site/Timber Trails Ct., Howard County,MD
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 9-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon,M.D. 111 Penn Street,Baltimore,MD 21201 VC
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-18 Rev 1/89

90-147

89 25731

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Robert Jenkins | | 9-13-89 | 4:59pm M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| | 1 [X] M 2 [ ] F | 60 YRS. | | | 4/21/29 | |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 2201 Walbook Ave Apt.G-05 | Baltimore City | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | | BALTIMORE CITY | 1 [ ] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2201 WALBROOK AVE. | | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| - | - | - | - |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| - | - |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| THELMA QUEEN | 1412 N. CHESTER ST., BALTIMORE, MD. |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal | | |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Stanley S White 9-20-89 | STATE ANATOMY BOARD, BALTO., MD. 21201 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |
| Inspection | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Chas P. Kokes MD | OCME | 9-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Charles P. Kokes, M.D 111 Penn Street Balto.,MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 52131

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE A. JOHNSON, SR. | | | 2. DATE OF DEATH (Month / Day / Year): 09 / 18 / 89 | 3. TIME OF DEATH: 11:60 P M |
| 4. SOCIAL SECURITY NUMBER: 214-26-3084 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 09 18 29 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 3413 CHESTNUT AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3413 CHESTNUT AVENUE | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1949-1952 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISPATCHER | 16b. KIND OF BUSINESS/INDUSTRY: BALTO. CITY HWY DEPT. | |
| 17. FATHER'S NAME (First, Middle, Last): EDWARD E. JOHNSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN HARRIS | | |
| 19a. INFORMANT'S NAME (Type/Print): JANET JOHNSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3413 CHESTNUT AVENUE, BALTO., MD. 21211 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD. VETERANS CEMETERY | 20c. LOCATION — City or Town, State: GARRISON FOREST, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr | 22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYELOGENOUS LEUKEMIA | 9 MOS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 27a. DATE OF INJURY (Month, Day, Year) | 27b. TIME OF INJURY M | 27c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 27d. DESCRIBE HOW INJURY OCCURED |
| 27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 27f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD | 29c. LICENSE NUMBER: D35606 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 711 W 40 ST BALT MD 21211 - SAMUEL ZAUER

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

89 25733

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Madeleine Sherlock Key | | | 2. DATE OF DEATH (Month, Day, Year): 09 19 89 | 3. TIME OF DEATH: 6:00 A M |
| 4. SOCIAL SECURITY NUMBER: 220-03-4586 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04-13-02 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 21211 3838 Roland Avenue Apt. 903 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: ------- |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: ------ | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3838 Roland Avenue, Apt. 903 | | 10f. ZIP CODE: 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATNER'S NAME (First, Middle, Last): Henry Eisenbrandt | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanor "Unknown" | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas H. Sherlock | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1011 Rolandvue Avenue, Towson, MD 21204 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. | | 20c. LOCATION — City or Town, State: Balto., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb | | 22. NAME AND ADDRESS OF FACILITY: Cremation Society of MD Baltimore, Maryland 21228 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter tha mode of dying, such ae cardiec or respiratory arrest, ahock, or heart failure. List only ona cause on aach line.

| | | Approximata Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Cardiac arrhythmia | Sudden |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequantially list conditions, if eny, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. arteriosclerotic heart disease | 5 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Fractured right hip, compression | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Complicated Osteoporosis | 10 years |

PART II. Other significent conditions contributing to death but not resulting in tha underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| E. Hunter Wilson MD | D14487 | 9/19/89 |

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): E. Hunter Wilson, M. D. 705 Medical Arts Bldg. Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Jiha Davidson-Randall |

DHMH-18 Rev 1/89

89 25734

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian E. King | | | 2. DATE OF DEATH (Month, Day, Year): September 19 1989 | 3. TIME OF DEATH: 6:30 P M |
| 4. SOCIAL SECURITY NUMBER: 214-14-3048 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05/31/11 | 8. BIRTHPLACE (State or Foreign Country): N.C |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Bettsville | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Jessup | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8710 Mission Rd | 10f. ZIP CODE: 20794 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Alex Yancey | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Yancey | |
| 19a. INFORMANT'S NAME (Type/Print): Katie Davenport | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8710 Mission Rd Jessup md 20794 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Btata 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus MD | 20c. LOCATION — City or Town, State: Arbutus, md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lola March | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory arrest | minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal failure | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Hypotension | 3 weeks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status epilepticus; Hypovantilation; Hypoxic encephalopathy, dysphagia; Hypertension; Wolff-Parkinson-White syndrome; Morbid obesity; Anemia; Hyperkalemia, Hyponatremia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Hsiu Hung MD | 29c. LICENSE NUMBER: D25000 | 29d. DATE SIGNED (Month, Day, Year): September 20, '89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8357 Cherry Lane, Laurel, MD 20707 | PD-Hsiu Hung, M.D. | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25735

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Michael Anthony LEE
2. DATE OF DEATH (Month, Day, Year): 9 / 20 / 89
3. TIME OF DEATH: 12:20 PM
4. SOCIAL SECURITY NUMBER: 215 18-5536
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/25/52
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2007 Boone St
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BALTO. ASSO. FOR Retarded CitizENS
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Mckinley Lee
18. MOTHER'S NAME (First, Middle, Maiden Surname): Beulah M. Barney
19a. INFORMANT'S NAME (Type/Print): IDA Morsell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2007 BOONE St / BALTO. MD. 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Woodlawn MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: W.M. E. March Funeral Home 1101 E. North Avenue 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | End Stage Renal disease | 2 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Diabetes | 10 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Down's Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 9/20/89
28b. TIME OF INJURY: 12:20 PM
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: End Stage Renal Disease
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley M. Pamfilis MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY PAMFILIS MD 22 S. Greene St Baltimore 21201
31. DATE FILED (Month, Day, Year): 9/20/89 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

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89 25736

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Grace Lowery
2. DATE OF DEATH (Month, Day, Year): 9 21 89
3. TIME OF DEATH: 3:38 A M
4. SOCIAL SECURITY NUMBER: 218-60-4400
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 47 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-2-42
8. BIRTHPLACE (State or Foreign Country): S.C
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 605 Cherry Crest Rd
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Harry Jackson
18. MOTHER'S NAME (First, Middle, Maiden, Surname): Maude W. Williams
19a. INFORMANT'S NAME (Type/Print): James Cowery
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 Cherry Crest Rd Apt B Balto Md 21225
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park
20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lola Marsh
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respinatory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Myocardial Infarction 8-88
DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic Obstructive Lung Disease

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Obesity
Hypertension
Cigarette Abuse

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D31744
29d. DATE SIGNED (Month, Day, Year): 09-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4910 Pennington Ave. Baltimore md. 21226
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25136

89 25737

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH LAVENDER | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 17 89 | 3. TIME OF DEATH: 6 :16AM M |
| 4. SOCIAL SECURITY NUMBER: 207-14-2203 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 29, 1902 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | 9c. COUNTY OF DEATH: PRINCE GEORGE'S | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Capitol Heights | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6900 Pepper Street | 10f. ZIP CODE: 20743 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): Harold Lavender | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 Upsal Street, Philadelphia, PA. | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park | 20c. LOCATION — City or Town, State: Landover, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Stewart, III | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd,., N.E. Wash. D.C. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Septicemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Infected Decubiti | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dehydration, Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD | 29c. LICENSE NUMBER: D15104 | 29d. DATE SIGNED (Month, Day, Year): 9/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): I. SURY. MD 6005 LANDOVER RD. CHEVERLY MD 20785

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

MEDICAL EXAMINER NOTIFIED
DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25737

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25738
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): O. W. LENTZ | | 2. DATE OF DEATH (Month, Day, Year): 9 20 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 241-09-2436 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-22-1913 |
| 8. BIRTHPLACE (State or Foreign Country): N. C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3405 W. FOREST PARK | 10f. ZIP CODE: BALTO. 21216 | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES LENTZ | 16. MOTHER'S NAME (First, Middle, Maiden Surname): DAISY CARPENTER | | |
| 19a. INFORMANT'S NAME (Type/Print): GENEVA LENTZ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 W. FOREST PARK AVENUE: BALTO, MD 21216 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) ENTOMBMENT | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE CO, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett | 22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] ND |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9/20/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Lucius L. Cross M.D. | | ▶ 9/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 700 Washington Blvd. Balt MD. 21223

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 28 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25739

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jennifer Christine Martin | | 2. DATE OF DEATH (Month, Day, Year): 9 18 89 | 3. TIME OF DEATH: 12:35 a M |
| 4. SOCIAL SECURITY NUMBER: 215-94-4332 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 11 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-1-78 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 409 Annabel Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: ====== | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ====== | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 409 Annabel Avenue | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sherry Davis | | |
| 19a. INFORMANT'S NAME (Type/Print): Laura Paskoski | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 Jack Street Baltimore, Maryland 21225 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Franciewicz | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Maryland21225 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Smoke and Soot Inhalation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
| | Inspection | |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-18-89 | 28b. TIME OF INJURY: 12:16a M | 28c. INJURY AT WORK? 1 ☐ YES ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Victim in house fire | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 409 Annable Ave., Balto,MD | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes, M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-18-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St. Baltimore,MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25740
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): KERRY ANN McDaniel

**2. DATE OF DEATH** Month: 9 Day: 18 Year: 89

**3. TIME OF DEATH**: 12:35 AM

**4. SOCIAL SECURITY NUMBER**: 215-96-0094

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 8 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 09-21-80

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): 409 Annabel Avenue

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**: ======

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: ======

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 409 Annabel Avenue

**10f. ZIP CODE**: 21225

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIOIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed) — Elementary/Secondary (0-12): 3rd Grade — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Student

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Joseph McDaniel

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Sherry Davis

**19a. INFORMANT'S NAME** (Type/Print): Laura Paskoski

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 Jack Street Baltimore, Maryland 21225

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Glen Haven Memorial Park

**20c. LOCATION — City or Town, State**: Glen Burnie, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Jerome Framewerks

**22. NAME AND ADDRESS OF FACILITY**: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory arreet, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Smoke and Soot Inhalation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO — Inspection

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☒ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): 9-18-89

**28b. TIME OF INJURY**: 12:16a M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☒ NO

**28d. DESCRIBE HOW INJURY OCCURED**: Victim in house fire

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify): Home

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): 409 Annabel Ave., Balto., MD

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles P. Kokes, M.D.

**29c. LICENSE NUMBER**: OCME

**29d. DATE SIGNED** (Month, Day, Year): ▶ 9-18-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Charles P. Kokes, M.D. 111 Penn St. Baltimore, MD 21201

**31. DATE FILED** (Month, Day, Year): SEP 22 1989

**32. REGISTRAR'S SIGNATURE**: Julia Knudsen-Randall

DHMH-16 Rev 1/89

12

89 25741

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM RICHARD MILLAR | | | 2. DATE OF DEATH: MONTH 9-17-89 DAY YEAR | 3. TIME OF DEATH: 4:16pm M |
| 4. SOCIAL SECURITY NUMBER: 212-46-8169 | 5. SEX: XX 1 M 2 F | 6. AGE (In yrs. last birthday): 42 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-12-1946 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): University of Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore,City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1214 ANGLESEA STREET | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4 or 8+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ASSEMBLY | 16b. KIND OF BUSINESS/INDUSTRY: GENERAL MOTORS CORP. | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM DECKER MILLAR | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): THERESA ELIZABETH MILLS | |
| 19a. INFORMANT'S NAME (Type/Print): THERESA ELIZABETH MILLAR | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 ANGLESEA STREET BALTIMORE, MD 21224 | | |
| 20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK 9-21-1989 | 20c. LOCATION — City or Town, State: CUMBERLAND, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Head Injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 ☐ NO | XX YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-17-89 | 28b. TIME OF INJURY: 3:40p M | 28c. INJURY AT WORK? 1 ☐ YES XX NO | 28d. DESCRIBE HOW INJURY OCCURED: Driver in Auto/Auto Collision |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1100 Blk E. Patapsco Ave Baltimore,Md |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Baltimore,MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Gusha Davidson-Randall |

OHMN-16 Rev 1/89

4

Itme:6 per FH G-655
9-28-89 cm

89 25742

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George William Conrad Myers IV
2. DATE OF DEATH: MONTH 9- DAY 16- YEAR 89
3. TIME OF DEATH: 9:25PM M
4. SOCIAL SECURITY NUMBER: Infant
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 0 YRS. IF UNDER 1 YEAR: MONTHS 0 DAYS 0 IF UNDER 24 HRS.: HOURS 13 MIN. 40
7. DATE OF BIRTH (Month, Day, Year): 9-16-89
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1240 Delbert Avenue
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Infant N/A; College (1-4 or 5+): Infant N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): George William Conrad Myers III
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marianne Elizabeth BOEHNLEIN
19a. INFORMANT'S NAME (Type/Print): GEORGE W.C. MYERS III
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1240 DELBERT AVENUE BALTIMORE, MD 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF JESUS 9-20-89
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott P. Gardner
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Distress of the newborn | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Prematurity | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER: D 22511
29d. DATE SIGNED (Month, Day, Year): ▶ 9/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sita Kottapalli 9000 Franklin Square Drive Balto Md 21237
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25743

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LILLIAN M. MYERS | | | 2. DATE OF DEATH: MONTH 9 DAY 20 YEAR 89 | 3. TIME OF DEATH: 3:40P. M |
| 4. SOCIAL SECURITY NUMBER: 212-16-9017 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/20/04 | 8. BIRTHPLACE (State or Foreign Country): Washington, D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center-Catonsville | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: P.G. | 10c. CITY, TOWN OR LOCATION: New Carrollton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8333 Carrollton Parkway | | 10f. ZIP CODE: 20784 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Entertainer | 16b. KIND OF BUSINESS/INDUSTRY: Vaudeville (Entertainment) | |
| 17. FATHER'S NAME (First, Middle, Last): Walter McCormick | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Shephard | |
| 19a. INFORMANT'S NAME (Type/Print): Jaccie Flanders | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8333 Carrollton Parkway New Carrollton, Md. 20784 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorraine Park Maus. | 20c. LOCATION — City or Town, State: Woodlawn, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L. [illegible] | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO-PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DYSPLASTIC ANEMIA.
PERNICIOUS ANEMIA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: N.B. Vellanki | 29c. LICENSE NUMBER: D. 30469 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-22-1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N.B. Vellanki, Howard County Med. Bldg. 9055 Chevrolet Dr. Suite 101 Ellicott City, Md.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |

DNMN-16 Rev 1/89

89 25143

89 25744

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SHIRLEY McCONNELL | | 2. DATE OF DEATH (Month, Day, Year): 9 13 89 | 3. TIME OF DEATH: 5:10 a.m. |
| 4. SOCIAL SECURITY NUMBER: 219-36-4403 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04-30-1938 |
| 8. BIRTHPLACE (State or Foreign Country): MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 104 Cherry Lane | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | 9c. COUNTY OF DEATH: Anne Arundel | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 104 Cherry Lane | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 15b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Wilbert L. Brooks | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances C. Hines | | |
| 19a. INFORMANT'S NAME (Type/Print): William McConnell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 Cherry Lane Glen Burnie, MD 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | 20c. LOCATION — City or Town, State: Balt MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Turnell B. Cade, Sr. | 22. NAME AND ADDRESS OF FACILITY: Third Full Gospel Baltimore, MD 21217 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complicetions thet ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METHASTATIC BREAST CANCER | 26 mos |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William P. McGuire, M.D | D16801 | ▶ 9-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM P. McGUIRE, M.D 600 N. WOLFE BALTIMORE MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Pendarvis |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2514

89 25745

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Carrie Virginia Matthews | | | | 2. DATE OF DEATH: MONTH 9 DAY 11 YEAR 89 | 3. TIME OF DEATH: 7:45 P M |
| 4. SOCIAL SECURITY NUMBER: 212-12-9005 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 101 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-26-1888 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 122 Roesler Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 122 Roesler Road | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY? United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): George Nicholson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Queen | |
| 19a. INFORMANT'S NAME (Type/Print): Elva Williams | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 Roesler Rd, Glen Burnie MD 2106 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Saint Rest | 20c. LOCATION — City or Town, State: Harmon, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jurrell B. Cole Sr | 22. NAME AND ADDRESS OF FACILITY: 1637 Druid Hill Ave Baltimore, MD 21217 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions thet ceused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, ahock, or haart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →
a. Cardiorespiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST
b. Metastatic Liver Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Suspected Primary Stomach
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 ☐ MEOICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sandra L. Howard, M.D. | 29c. LICENSE NUMBER: D27027 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Sandra L. Howard, M.D., 1600 S. Charles Street, Baltimore, MD 21230

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall |

DHMH-16 Rev 1/89

89 25746

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IDA MC CLEMENS | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 9 89 | 3. TIME OF DEATH: 2:35 AM |
| 4. SOCIAL SECURITY NUMBER: 219-54-3635 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/1/1898 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1217 W. FAYETTE ST. | | 10f. ZIP CODE: 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in-state removal | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] 9-20-89 | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure (Acute) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. (R) Pneumonitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Recent Cerebrovascular Accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Acute Renal Failure | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia
Clostridium Deficile Colitis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D18711 | ▶ Sept. 9 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARDO L. GONZALES JR — BON SECOURS HOSPITAL 2000 W. BALTIMORE ST., Md. 21223

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | [signature] |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

09 2576

Unknown 89-112

89 25747

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|
| ALEXANDER | MAGEE | 7 / 28 / 89 | 12:31 a M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| — | 1 [X] M 2 [ ] F | 28 YRS. | | | 4 23 61 | — |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Prince Georges General Hospital | Cheverly | Prince Georges |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| New York | — | Brooklyn | 1 [ ] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 320 Miller Avenue | | |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | — | — |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| — | MATTIE MAGEE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MATTIE MAGEE | 320 MILLER AVE., BROOKLYN, N.Y. |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) | | |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] 9-20-89 | STATE ANATOMY BOARD, BALTO., MD. 21201 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gun Shot Wound of Chest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 7/27/89 | 11:58p M | 1 [ ] YES 2 [X] NO | Subject was shot |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| street | Prince Georges, Md. 1115 Malley Rd., Landover |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | 7/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D., 111 Penn Street, Baltimore, Maryland 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | [signature] |

DHMH-16 Rev 1/89

09 2514?

89 25748

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gertrude Maxfield | | | 2. DATE OF DEATH (Month, Day, Year): 9 20 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 212-50-5784 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12 10 03 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): SETON HILL MANOR | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 501 WEST FRANKLIN STREET | | 10f. ZIP CODE: 21201 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print): ESTHER BONNETT | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3938 BEECH AVENUE, BALTIMORE, MD. 21211 | | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMTERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr | | 22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmias.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Electrolyte imbalance, Dementia, Autoimmune hemolytic anemia.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: D32158

29d. DATE SIGNED (Month, Day, Year): ▶ 9/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 501 W. FRANKLIN ST., BALTO., MD.

31. DATE FILED (Month, Day, Year): SEP 22 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25148

OAKLEY, JOHN
02/05/59 M JR.
89 25749

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN OAKLEY JR. | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 17, 1989 | 3. TIME OF DEATH: 2:15P M |
| 4. SOCIAL SECURITY NUMBER: 217-70-0737 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 30 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 2-5-59 | 8. BIRTHPLACE (State or Foreign Country): MD. | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 125 NORTH COLVIN STREET APT. 9K | | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indien, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN OAKLEY SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): PALESTINE PEOPLES | |
| 19a. INFORMANT'S NAME (Type/Print): LAVENIA M. OAKLEY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 NORTH COLVIN STREET/BALTIMORE, MD. APT. 9K 21202 | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Anthony E. Ward Jr. | 22. NAME AND ADDRESS OF FACILITY: WM.C.MARCH F.H. 1101 E. NORTH AVENUE | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory srrest, shock, or heert failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Thrombotic thrombocytopenic purpura | 3 days |
| Sequentielly list conditions, if any, leeding to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) | |
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Pending investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 YES 2 NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael C. McDevitt MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): Michael A. McDevitt, Medicine, 1830 Monument St, Johns Hopkins Hospital, Baltimore MD 21205 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DHMH-16 Rev 1/89

2

89 25750

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY T. O'HARA | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 15 / 1989 | 3. TIME OF DEATH: 11:30 PM |
| 4. SOCIAL SECURITY NUMBER: 219-56-7014A | 5. SEX: 1 ☐ M 2 ☑ F XXX | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH: 2-25-1922 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER | | 9c. COUNTY OF DEATH: CARROLL |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: WESTMINSTER | | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1046 HOOK ROAD | | 10f. ZIP CODE: 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6TH GRADE; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED | 16b. KIND OF BUSINESS/INDUSTRY: N/A | | |
| 17. FATHER'S NAME (First, Middle, Last): RICHARD O'HARA | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EDNA BOBLITZ | | |
| 19a. INFORMANT'S NAME (Type/Print): MARGARET McCAULEY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8142 DELHAVEN ROAD BALTIMORE, MARYLAND 21222 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial XX 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SEPTICEMIA | 2 WKS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PERFORATED GASTRIC ULCER | 2 WKS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: ARDS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M |
| 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Norman Goldstein | 29c. LICENSE NUMBER: D26385 | 29d. DATE SIGNED (Month, Day, Year): 9/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Norman Goldstein 218 Washington Hgts Rd Ext Westminster, Md. 21157

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 21 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25751

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN PICKETT | | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 21 89 | 3. TIME OF DEATH: 12 45AM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/17/08 | 8. BIRTHPLACE (State or Foreign Country): SC |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGE'S |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: DC | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Washington | 10d. INSIDE CITY LIMITS? XX[X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: d 3082 Clinton St NE | | 10f. ZIP CODE: 20018 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+): 6 Yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Educational | |
| 17. FATHER'S NAME (First, Middle, Last): John P Pickett Sr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie H Hamlin | |
| 19a. INFORMANT'S NAME (Type/Print): Betty Spencer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a,c,b,d,e, &f | |
| 20a. METNOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other final place): Camden Cemetery Campbell, STreet | 20c. LOCATION — City or Town, State: Camden, SE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hazel Plummer | | 22. NAME AND ADDRESS OF FACILITY: John T Rhines Co 3015 12th St NE, DC 20017 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | MINUTES |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SEPTIC SHOCK | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. PNEUMONIA | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. MAL NUTRITION | MONTHS. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTIPLE CEREBRAL INFARCTIONS
ALZHEIMERS DISEASE
DECUBITI ULCERS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] PHYSICIAN. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMN-16 Rev 1/89

89 25752

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CATENA A. PRIVITERA (Catena Priviteria) | | 2. DATE OF DEATH (Month, Day, Year): 9 18 89 | 3. TIME OF DEATH: 6 05 A M |
| 4. SOCIAL SECURITY NUMBER: 220-86-2641 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-24-13 |
| 8. BIRTHPLACE (State or Foreign Country): Italy | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Deaton Hospital + Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3929 CHESTERFIELD AVENUE | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -- ; College (1-4 or 5+): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): CARMELO CONTI | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA MIRABILE | | |
| 19a. INFORMANT'S NAME (Type/Print): CAMELLA PALAIA - DAUGHTER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3929 CHESTERFIELD AVE, BALTIMORE, MD. 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER | 20c. LOCATION — City or Town, State: BALTO, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cinda Hoyle | 22. NAME AND ADDRESS OF FACILITY: 3331 BREHMS LANE 21213 SCHIMUNEK FUNERAL HOME | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 5 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Multi infarct dementia | 7 yrs |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atonic Stomach

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H. L. Muncie, Jr MD | 29c. LICENSE NUMBER: D14622 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. L. Muncie, Jr MD 601 S. Charles St. Balto, Md 21230 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Item 19, film G655 9-27-89 I.J.

2+1

89 25753

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Anthony C. Pusloskie / ANTHONY PUSLOSKIE
2. DATE OF DEATH: MONTH 9 DAY 21 YEAR 89
3. TIME OF DEATH: 10:30 AM
4. SOCIAL SECURITY NUMBER: 214-50-4110 / 214-50-4110
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 40 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/29/49
8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): LOCH RAVEN V A HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MARYLAND
9c. COUNTY OF DEATH: --

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? YES 2 [X] NO
10e. STREET AND NUMBER: 22 D. Starwood Court
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: VIET NAM
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yr. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Road Construction

17. FATHER'S NAME (First, Middle, Last): Michael Pusloskie
18. MOTHER'S NAME (First, Middle, Maiden Surname): Deloris Phelps

19a. INFORMANT'S: Ruth ~~Rozub~~ KOZUB - sister
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 Sequoia Drive, Edgewood, Md. 21040

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hills Cem.
20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eugene J Lautner Jr
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Arrest | 0 |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Pneumonia | 2 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Laryngeal cancer (squamous cell) metastatic | 3 mos |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypercalcemia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel J Skiest MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Daniel J. Skiest MD
31. DATE FILED (Month, Day, Year): 9 SEP 22 1989
32. REGISTRAR'S SIGNATURE: Sheba Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25754

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA Virginia J. Pugh PUGH | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 20, 1989 | 3. TIME OF DEATH: 3:17 A M |
| 4. SOCIAL SECURITY NUMBER: 400-40-8937 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02-24-31 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Ohio | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Kettering | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4715 Fawnwood Road | | 10f. ZIP CODE: 45429 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Warren F. Joplin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Belle Sale | |
| 19a. INFORMANT'S NAME (Type/Print): Cornelius Pugh, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4715 Fawnwood Road, Kettering, Ohio 45429 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc. | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb | | 22. NAME AND ADDRESS OF FACILITY: Cremation Society of Maryland 299 Frederick Rd., Balto., MD 21228 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Subdural Hematoma | 14 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Burr hole placement | 14 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Jan Weingart MD | C | 9/00/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J Weingart MD Johns Hopkins Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | |

DHMH-16 Rev 1/89

89 25755

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gloria E. Pope | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 16 / 89 | 3. TIME OF DEATH: 11:30 PM |
| 4. SOCIAL SECURITY NUMBER: 218-26-4504 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (in yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5-21-30 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4907 Reistertown Rd | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Harvey Epps Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Loretta Epps | | |
| 19a. INFORMANT'S NAME (Type/Print): Victoria Dubose | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2041 N. Fulton Ave. Balto. Md. 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cem. | 20c. LOCATION — City or Town, State: Catonsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Cecil A Estep | 22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hepatic encephalopathy | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | End Stage Liver failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William A. Frame MD | 29c. LICENSE NUMBER: D 38483 | 29d. DATE SIGNED (Month / Day / Year): 9/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William A. Frame MD - 2600 Liberty Hgts Blvd. Balto

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 52122

89 25756

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GENEVIEVE ENOLA RAMSEY | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: 5:30 A.M. |
| 4. SOCIAL SECURITY NUMBER: 216-32-9522 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/09/16 |
| 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2325 EASTERN AVE. | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7TH GRADE; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN WILSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLY PATTERSON | | |
| 19a. INFORMANT'S NAME (Type/Print): JACK RAMSEY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2325 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK 9-22-89 | 20c. LOCATION — City or Town, State: DORSEY, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas W. Fisher | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYOCARDIAL INFARCTION — DUE TO (OR AS A CONSEQUENCE OF): | Sudden |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
SEVERE CHRONIC RHEUMATOID ARTHRITIS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore T Niznik MD | 29c. LICENSE NUMBER: D0 75 17 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theodore T. NIZNIK 429 S Chester St Balto MD 21231 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | DR. THEODORE T. NIZNIK, M.D. CHURCH HOSPITAL |

DHMH-18 Rev 1/89

89 25756

89 25757

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles ROBINSON
2. DATE OF DEATH — MONTH DAY YEAR: September 18, 1989
3. TIME OF DEATH: 1:45 a M
4. SOCIAL SECURITY NUMBER: 217 05 6049
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 25, 1915
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): VAMC, Fort Howard, Maryland 21052
9b. CITY, TOWN OR LOCATION OF DEATH: Fort Howard
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 233 North Culver Street
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Longshoreman
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): John Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Bell
19a. INFORMANT'S NAME (Type/Print): Clin.Rcds. VA Medical Center
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Fort Howard, Maryland 21052
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans
20c. LOCATION — City or Town, State: Owing Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lucil A Estep
22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory Arrest | 30 Minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Multiple Cerebral Vascular Accidents | 3 Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. High Blood Pressure | 15 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D 38118
29d. DATE SIGNED (Month, Day, Year): 9/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SERGIO MENENDEZ, M.D. VA MEDICAL CENTER FORT HOWARD, MARYLAND 21052
31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25758

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPHINE R. RZEPKOWSKI | | 2. DATE OF DEATH (Month, Day, Year): 09 20 89 | 3. TIME OF DEATH: 5:55 AM |
| 4. SOCIAL SECURITY NUMBER: 218-07-3360 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03/01/08 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: - | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: PASADENA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7 KELLINGTON DRIVE | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER-OPERATOR | 16b. KIND OF BUSINESS/INDUSTRY: LIQUOR STORE | |
| 17. FATHER'S NAME (First, Middle, Last): JON HELINSKI | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE BLACHOWICZ | | |
| 19a. INFORMANT'S NAME (Type/Print): WALTER J. RZEPKOWSKI SR. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 KELLINGTON DR. PASADENA, MARYLAND 21122 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SAINT STANISLAUS | 20c. LOCATION — City or Town, State: BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mary L. Kaufmann | 22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral Ischemic Infarct
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Peripheral Vasc. diseases
DUE TO (OR AS A CONSEQUENCE OF):
c. Peripheral Vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Pneumonia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO — N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.B. Patel HOUSE OFFICER | 29c. LICENSE NUMBER: D-17753 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M.B. PATEL M.D. 3001 S. HANOVER ST. BALTIMORE, MARYLAND 21225 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall | | |

DHMH-16 Rev 1/89

89 25759

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John E RADWITCH | | | 2. DATE OF DEATH (Month, Day, Year): September 15, 1989 | 3. TIME OF DEATH: 2:25 AM |
| 4. SOCIAL SECURITY NUMBER: 217-16-0041 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/25/07 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: | 9c. COUNTY OF DEATH: Baltimore County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: — | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1206 H BRIDGE CROSSING ROAD | | 10f. ZIP CODE: | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): — | 16b. KIND OF BUSINESS/INDUSTRY: — | |
| 17. FATHER'S NAME (First, Middle, Last): — | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): — | |
| 19a. INFORMANT'S NAME (Type/Print): DEBORAH BATSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2006 PAULETTE DR., BALTIMORE, MD. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): | 20c. LOCATION — City or Town, State: |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] 9-20-89 | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adenocarcinoma unknown primary

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Chronic aspiration

DUE TO (OR AS A CONSEQUENCE OF):

c. Coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

d. Status post myocardial infarction

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gastritis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen G Smaldore DO Resident Franklin Sq Hosp. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen Smaldore, M.D. 9000 Franklin Square drive 21237 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

68 52123

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25760
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Jerry Lee Schwartz

**2. DATE OF DEATH** (Month, Day, Year): 9 18 89

**3. TIME OF DEATH**: 12:25a M

**4. SOCIAL SECURITY NUMBER**: 214-86-4502

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 26 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 3-14-63

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): 409 Annabel Ave.

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**: ======

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: ======

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 409 Annabel Avenue

**10f. ZIP CODE**: 21225

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th Grade
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Laborer

**16b. KIND OF BUSINESS/INDUSTRY**: Construction

**17. FATHER'S NAME** (First, Middle, Last): Donald R. Schwartz

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Margaret E. Dorn

**19a. INFORMANT'S NAME** (Type/Print): Donald Schwartz

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Johnson Road Pasadena, Maryland 21122

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Glen Haven Memorial Park

**20c. LOCATION — City or Town, State**: Glen Burnie, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Jerome Framworth

**22. NAME AND ADDRESS OF FACILITY**: Gonce Funeral Home
4001 Ritchie Hwy. Baltimore, Md. 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one ceuse on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Smoke Inhalation and Thermal Injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [X] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [X] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [X] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [ ] Natural [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): 9-18-89

**28b. TIME OF INJURY**: 12:16a M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [X] NO

**28d. DESCRIBE HOW INJURY OCCURED**: Victim in house fire

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify): Home

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): 409 Annabel Ave., Balto.MD

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles P. Kokes MD

**29c. LICENSE NUMBER**: OCME

**29d. DATE SIGNED** (Month, Day, Year): ▶ 9-18-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Charles P. Kokes, M.D. 111 Penn St. Baltimore, MD 21201

**31. DATE FILED** (Month, Day, Year): SEP 22 1989

**32. REGISTRAR'S SIGNATURE**: Gina Davidson-Randall

DHMH-16 Rev 1/89

1011.

Item 6 corrected per F.H. 9/25/89 reb

89 25761

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH P. SPENCE | | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 21, 1989 | 3. TIME OF DEATH: 5:30 AM |
| 4. SOCIAL SECURITY NUMBER: 237-28-0154 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 9, 1917 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): 3847 Shannon Drive - 21213 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: -- | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: -- | | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 3847 Shannon Drive | | | 10f. ZIP CODE: 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -- / College (1-4 or 5+): -- | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder | | 16b. KIND OF BUSINESS/INDUSTRY: Housing Authority City of Baltimore | |
| 17. FATHER'S NAME (First, Middle, Last): Lennie R. Spence | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Ausley | |
| 19a. INFORMANT'S NAME (Type/Print): Mary T. Spence - Wife | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3847 Shannon Drive, Baltimore, Md. 21213 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME 3331 Brehms Lane, Balto, Md. 21213 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. STAGE D CARCINOMA OF PROSTATE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph B. Murphy

29c. LICENSE NUMBER: D22564

29d. DATE SIGNED (Month, Day, Year):

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Joseph Murphy, 7402 York Rd, Suite #200, Towson, Md. 21204

31. DATE FILED (Month, Day, Year): SEP 22 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

09 2761

89 25762

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ~~Stewart~~ Bertina NMI Stewart | | | 2. DATE OF DEATH: MONTH 09 DAY 19 YEAR 89 | 3. TIME OF DEATH: 1:16A M |
| 4. SOCIAL SECURITY NUMBER: 219-10-8266 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-28-16 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1111 Harlem Ave 1st Fl | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: B |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): David Stewart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Chambers |
| 19a. INFORMANT'S NAME (Type/Print): Mary J. Jenkins | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 295 Harbor Dr. Lusby, MD. 20657 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem PK | 20c. LOCATION — City or Town, State: Balto. MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm C. Brown | 22. NAME AND ADDRESS OF FACILITY: 1206 W. North Ave Wm. C. Brown Community F.H. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PERIPHERAL VASCULAR DISEASE | 8 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter J Wisniewski MD WISNIEWSKI | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER L WISNIEWSKI MD 22 S. GREENE ST, BALTIMORE, MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): 9/18/89 SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

09 2752

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-25763

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FLETCHER HORACE SHAW | | 2. DATE OF DEATH (Month, Day, Year): Sept. 17, 1989 | 3. TIME OF DEATH: 8:10 A M |
| 4. SOCIAL SECURITY NUMBER: 409-24-1785 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1922 |
| 8. BIRTHPLACE (State or Foreign Country): Alabama | | | |
| 9a. FACILITY NAME (If not institution, give street and number): National Naval Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | 9c. COUNTY OF DEATH: Montgomery | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Virginia | 10b. COUNTY: Fairfax | 10c. CITY, TOWN OR LOCATION: Falls Church | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3303 Nevius Street | 10f. ZIP CODE: 22041 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1942-1973 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 6+): 5+ | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Naval Officer | 16b. KIND OF BUSINESS/INDUSTRY: Defense | |
| 17. FATHER'S NAME (First, Middle, Last): Fletcher Horace Shaw | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Birdie Idell Thornton | |
| 19a. INFORMANT'S NAME (Type/Print): Helen J. Shaw | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3303 Nevius Street, Falls Church, VA 22041 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery | 20c. LOCATION — City or Town, State: Arlington, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Tammy N. Shaw | 22. NAME AND ADDRESS OF FACILITY: Murphy Funeral Home, 1102 W. Broad St, Falls Church, VA 22046 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC ESOPHAGEAL CARCINOMA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29e. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: BP Monahan MD | 29c. LICENSE NUMBER: D-35835 | 29d. DATE SIGNED (Month, Day, Year): ▶ 31 Oct 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRIAN P. MONAHAN, LT, MC, USN | National Naval Medical Center, Bethesda, MD 20814-5011 | |
| 31. DATE FILED (Month, Day, Year): OCT 31 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

20

89 25764

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN Helen Beatrice SCHWIER | | | | 2. DATE OF DEATH (Month, Day, Year): 9-20-89 | 3. TIME OF DEATH: 1715 M |
| 4. SOCIAL SECURITY NUMBER: 212-28-6378 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 06-20-97 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: ------ | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3373 St. Benedict Street | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LPN | 16b. KIND OF BUSINESS/INDUSTRY: St. Agnes Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Harris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Becraft | |
| 19a. INFORMANT'S NAME (Type/Print): Frances C. Seiser | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6860 NW 62nd St. Rd. Ocala, FL 32675 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb | | 22. NAME AND ADDRESS OF FACILITY: MacNabb Funeral Home, P.A. Catonsville, Maryland 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CANCER GALLBLADDER | 0' MIN |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NEW ONSET SEIZURES, DEHYDRATION HYPERTENSION, CAD

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C Ravi MD | 29c. LICENSE NUMBER: D 37333 | 29d. DATE SIGNED (Month, Day, Year): 9.20.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI, MD, BCGH, RANDALLS TOWN, MD 21133 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

89 2576

89 25765

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Chan U SO | 2. DATE OF DEATH (Month, Day, Year): 9 / 20 / 89 | 3. TIME OF DEATH: 2:08 P M | |
| 4. SOCIAL SECURITY NUMBER: 575-17-6608 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 52 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 12-1-1936 | 8. BIRTHPLACE (State or Foreign Country): Korea | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hosp. Rossville Blvd. | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore, Co. | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3124 Acton Rd. | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: Korea | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Oriental |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress | 16b. KIND OF BUSINESS/INDUSTRY: In Home | |
| 17. FATHER'S NAME (First, Middle, Last): Jong Duk Lee | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sung | | |
| 19a. INFORMANT'S NAME (Type/Print): Sang So (Son) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3124 Acton Rd. Baltimore, Md. 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Cremetory | 20c. LOCATION — City or Town, State: Silver Spring, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Peter D. Cassell | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Homs, Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Subarachnoid Hemorrhage | |
| | DUE TO (OR AS A CONSEQUENCE OF): Rupture intracranial aneurysm | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Hatem Abdo M.D. | 29c. LICENSE NUMBER: 00593 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HATEM ABDO 1205 York Rd Lutherville MD 21093 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

89 2715S

Items:23,27 per ME G-656
10-18-89 cm

89 25766

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page(s) 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| BABY | Natoria | Turnage | 9-15-89 | 6:15AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| N/A | 1 ☐ M 2 ☒ F | YRS. | 1 / 6 | | 8-9-89 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Francis Scott Key Medical Center | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1812 CHILTON STREET | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| CHILD | | CHILD | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| NILES TURNAGE | VICTORIA McGILL |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| VICTORIA McGILL | 1812 CHILTON STREET/BALTIMORE, MARYLAND 21218 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MOUNT CALVARY CEMETERY | ANNE ARUNDEL CO., MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Wilfred Gaither | WM. C. MARCH F.H. 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SUDDEN INFANT DEATH SYNDROME | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell, M.D. | OCME | ▶ 9-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM . C. THOMAS. | | | 2. DATE OF DEATH: MONTH 09 DAY 21 YEAR 89 | 3. TIME OF DEATH: 3 30 PM |
| 4. SOCIAL SECURITY NUMBER: 395-52-6074 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05 07 12 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE. | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3233 Westmont Ave. | | 10f. ZIP CODE: 21216 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie | |
| 19a. INFORMANT'S NAME (Type/Print): Charles Thomas | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3233 Westmont Ave. Balto. Md. 21216 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chattanooga, Tenn. | 20c. LOCATION — City or Town, State: |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leitha M. Wainwright | | 22. NAME AND ADDRESS OF FACILITY: Wainwright Funeral Home 2700 Edmondson Ave. Balto. Md. 21223 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. RESPIRATORY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PNUEMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. METASTATIC CARCINOMA LUNG | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD. | | 29c. LICENSE NUMBER: D 23300 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9.21.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LIBERTY MEDICAL CENTER. 2600 Liberty Rd. BALTIMORE MD. | | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Dewey O. | VANGOSEN | | Sept. 15 1989 | 6:25 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 236-42-0761 | 1 ☐ M 2 ☒ F | 58 YRS. | | | 11/23/1930 | OHIO |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| FRANKLIN SQUARE HOSPITAL | ROSSVILLE | Baltimore County |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | DUNDALK | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 8033 NORTH BOUNDARY RD. | 21222 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ YES 2 ☐ NO KOREA | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th GRADE | | PLATE MILL | BETHLEHEM STEEL |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| CARTY B. VANGOSEN | LOUISE M. GANOE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| HELEN VANGOSEN | 8033 NORTH BOUNDARY RD. BALTIMORE, MD. 21222 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | UNION CHAPEL UNITED METHODIST 9/19/1989 | BERKLEY SPRING W. VA. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Chas W. Fisher | DUDA-RUCK FUNERAL HOME of DUNDALK, INC. 7922 WISE AVE. BALTIMORE MARYLAND 21222 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Cancer Of The Lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Nadeem Qamar | N/A | Sept. 15 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Nadeem Qamar M.D. 9000 Franklin Sq. Dr. Baltimore 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Cornelius Uncles | | | 2. DATE OF DEATH Month: 09 Day: 17 Year: 89 | 3. TIME OF DEATH: 11:15 A-M |
| 4. SOCIAL SECURITY NUMBER: 219-22-2821 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 02-08-21 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 124 W. Franklin St. Apt. 601 | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): NORMAN UNCLES | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CORNELIA RAYNE | |
| 19a. INFORMANT'S NAME (Type/Print): ROSITA UNCLES | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2418 W. LAFAYETTE AVE., BALTO., MD. 21216 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S Wade 9-20-89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. End Stage Renal Disease | 10 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumocystis Carnii Pneumonia (HIV+) | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV+

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. Timmis Carter MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3018 S. Paul Place Balt. Md. | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Gina Sullivan-Marbella | |

DHMH-18 Rev 1/89

89 25769

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25770

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELENA WASHINGTON
2. DATE OF DEATH — MONTH: 9 DAY: 20 YEAR: 89
3. TIME OF DEATH: 5:55 PM
4. SOCIAL SECURITY NUMBER: 209-46-0779
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05/02/22
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALT

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 317 Ilchester Avenue
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Aide
16b. KIND OF BUSINESS/INDUSTRY: Retired
17. FATHER'S NAME (First, M...): Tom Henry
16. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Jones
19a. INFORMANT'S NAME (Type/Print): James Washington
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 Ilchester Avenue / Balto. MD 21218
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): First Rock Bapt. Church
20c. LOCATION — City or Town, State: Farmville, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis
22. NAME AND ADDRESS OF FACILITY: Wm. S. March Funeral Home 1101 E. North Avenue 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DECUBITI

DUE TO (OR AS A CONSEQUENCE OF):

c. RESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Terance Lamb MD
29c. LICENSE NUMBER: D37203
29d. DATE SIGNED (Month, Day, Year): ▶ 9-20-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TERANCE LAMB LIBERTY MEDICAL CENTER - BALTIMORE

31. DATE FILED (Month, Day, Year): SEP 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

88 52110

89 25771

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 6 may be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2, 3 should be detached for use as the burial-transit permit. Pages 4, 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES F. WILLIAMS | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: 12:20 P M |
| 4. SOCIAL SECURITY NUMBER: 217-52-9010 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/8/50 | 8. BIRTHPLACE (State or Foreign Country): N. C. |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3019 Seamon Avenue | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY? U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Walter Williams | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cleo Davis | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Williams | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3019 Seamon Avenue Baltimore, Md 21225 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerome A. Thompson Jr | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hemolytic Anemia — 14 days

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acquired Immune deficiency syndrome years

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

disseminated cytomegalovirus infection
disseminated Pneumocystis infection
disseminated mycobacterium Avium-Intracellular

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Steven J O'Day MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven John O'Day MD | 600 N. Wolfe St, Rubelle. MD. The Johns Hopkins Hospital 21205 | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 25772

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Charlotte | A. | WILSON | September 21 1989 | 4:D A. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 235-20-5851 | 1 ☐ M 2 ☒ F XX | 67 YRS. | | | March 1, 1922 | West Virginia |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Franklin Square Hospital | Rossville | Baltimore Co. |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore Co. | Dundalk | 1 ☐ YES 2 ☒ XX NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3431 Cornwall Road | 21222 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ XX NO | 1 ☐ YES 2 ☒ XX NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 Years | ---------- | Housewife | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John F. Bloom | Lillian Sheets |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carolyn L. Lambert | 3431 Cornwall Road Baltimore, Maryland 21222 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XXX 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Bluemont Cemetery | Grafton, W. Virginia |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | William E. Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis - Staph Aureus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Meningitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ X NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | | ▶ 9-21-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Stanley Kman, M.D. 9000 Franklin Square Dr., Baltimore, MD 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 22 1989 | [signature] |

DHMH-16 Rev 1/89

89 25773

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Howard Wakefield | | | 2. DATE OF DEATH: MONTH 9 DAY 18 YEAR 89 | 3. TIME OF DEATH: 2:05 PM |
| 4. SOCIAL SECURITY NUMBER: 193-14-8575 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct 19, 1926 | 8. BIRTHPLACE (State or Foreign Country): Lancaster, Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: W. Va. | 10b. COUNTY: Jefferson | 10c. CITY, TOWN OR LOCATION: Shenandoah Junction | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: P.O,. Box 410 | | 10f. ZIP CODE: 25442 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY: Sugar Transportation |
| 17. FATHER'S NAME (First, Middle, Last): Lloyd N. Wakefield | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Violet Bisking | | |
| 19a. INFORMANT'S NAME (Type/Print): Helen S. Wakefield | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 410 Shenandoah Junction, W. Va. 25442 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rosedale Cemetery | | 20c. LOCATION — City or Town, State: Martinsburg, W.Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Dallas Sluck #100535 | | 22. NAME AND ADDRESS OF FACILITY: Rosedale Funeral Chapel 2060 Rosedale Rd, Mtsbg, W.Va., 25401 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES [X] NO Inspection | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St., Baltimore, MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 22 1989 | 32. REGISTRAR'S SIGNATURE | |

DHMH-16 Rev 1/89

89 25774

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PAULMER, ZIMMERMAN | | | 2. DATE OF DEATH — MONTH: 9 DAY: 10 YEAR: 89 | 3. TIME OF DEATH: 10 09 PM |
| 4. SOCIAL SECURITY NUMBER: 234-30-0254 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/22/24 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 420 CLAREWAY AVENUE | | 10f. ZIP CODE: — | 10g. CITIZEN OF WHAT COUNTRY? — |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: ~~White~~ White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): — | 16b. KIND OF BUSINESS/INDUSTRY: — |
| 17. FATHER'S NAME (First, Middle, Last): — | 18. MOTHER'S NAME (First, Middle, Maiden Surname): — | |
| 19a. INFORMANT'S NAME (Type/Print): — | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): — | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): | 20c. LOCATION — City or Town, State: |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] 9-20-89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. HOUSE STAFF | 29c. LICENSE NUMBER: D38737 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH VASSALOTTI MD, FRANCIS SCOTT KEY | | |
| 31. DATE FILED (Month, Day, Year): 9/SEP 25 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25774

89 25775

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| JOHN | JOSEPH | ANGELLATTA | 09 / 14 / 89 | 10:33pm M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-10-4128 | 1 [X] M 2 [ ] F | 81 YRS. | | | 09-08-1908 | WV |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| SACRED HEART HOSPITAL | Cumberland | ALLEGANY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Allegany | LaVale | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Route 1 Box 226 | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO | white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | retired Kelly-Springfield | Tire Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Frank Angellatta | Christina (Minn) Angellatta |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ruth Angellatta | Route 1 Box 226, LaVale, MD 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | St. Marys Cemetery | Cumberland, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. High Probability Pulmonary embolism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. LLL Pneumonia - Bronchitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Recurrent Stroke - unable to swallow - dysphasia | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD - CAD - MI
Diabetes II on Insulin

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Felipa MD | D13601 | ▶ 9/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. FELIPA 925 BISHOP WALSH RD. CUMBERLAND, MD. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 19 1989 | Lia Davidson-Randall |

DHMH-16 Rev 1/89

89 25775

89 25776

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ADRINE MALCOLM ABEL
2. DATE OF DEATH: MONTH 9 - DAY 12 - YEAR 89
3. TIME OF DEATH: 2:00 A M
4. SOCIAL SECURITY NUMBER: 213 20 9750
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-31-11
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND, MD
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 314 Pulaski Street
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician
16b. KIND OF BUSINESS/INDUSTRY: Hairdressing
17. FATHER'S NAME (First, Middle, Last): Harry Malcolm
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah F. Kelly
19a. INFORMANT'S NAME (Type/Print): Hazel Hinea
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 Pulaski Street-Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Omps Crematory
20c. LOCATION — City or Town, State: Winchester, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hendy D. Upchurch
22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Status Epilepticus — Respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Previous Stroke - Recent Hemorrhagic Stroke | 24 d. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Severe ASCVD. ± CHF - (AF). | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Severe COPD - Bronchial Asthma - End Stage Resp. Disease | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism
Malnourishment - not eating x weeks
Pulmonary Hypertension due to COPD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: V. Felipa MD
29c. LICENSE NUMBER: D13601
29d. DATE SIGNED (Month, Day, Year): ▶ 9/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. RUAL FELIPA, M.D., 925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502
31. DATE FILED (Month, Day, Year): SEP 13 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

OHMH-18 Rev 1/89

#10 per F.H., H.D

89 25777

1 - FOR STATE REGISTRAR 12/15/89 KW

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ANN | THOMPSON | BOYD | SEPT. 9, 1989 | 12:24 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 087-03-8464 | 1 ☐ M 2 ☒ F | 85 YRS. | | | 10/31/03 | WV |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| FROSTBURG VILLAGE NURSING HOME | FROSTBURG | ALLEGANY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| FROSTBURG HEIGHTS APARTMENTS APT. 416 | 21532 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 4 | | DIR. OF TRAINING | HEARNS DEPT. STORE |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JAMES FURLONG THOMPSON | MINNA RAY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. SUSAN DAVID | 1030 BISHOP WALSH DR., CUMBERLAND, MD 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | SMITHBURG CREMATORY | SMITHBURG, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Marilou M. Sowers | 60 W. MAIN STREET SOWERS FUNERAL HOME FROSTBURG, MD 21532 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO RESPIRATORY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASPIRATION PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETUS MELLITUS.
ORGANIC BRAIN SYNDROME
RECURRENT URINARY TRACT INFECTION

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| S. Chang MD | D25638 | ▶ 9/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S. T. CHANG, M.D. FROSTBURG PLAZA, FROSTBURG, MD 21532

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 14 1989 | Julia Davidson-Kendall |

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

89 25778

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN F BLUBAUGH | | 2. DATE OF DEATH (Month, Day, Year): September 8, 1989 | 3. TIME OF DEATH: 1:15 P.M |
| 4. SOCIAL SECURITY NUMBER: 217-10-1060 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-3-1897 |
| 8. BIRTHPLACE (State or Foreign Country): Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: Allegany | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Frostburg | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Rt. 1, Box 404 | 10f. ZIP CODE: 21532 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW I | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Contractor | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): James Walter Blubaugh | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanora Thrasher | | |
| 19a. INFORMANT'S NAME (Type/Print): Ida Edna Blubaugh | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt1, Box 404 Frostburg, Md. 21532 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Laurel Hill Cemetery | 20c. LOCATION — City or Town, State: Moscow Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John E McKenzie | 22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio - Respiratory Arrest. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute or Chronic Bronchitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Advanced Interstitial Lung Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Coronary Artery Disease. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D-23371 | 29d. DATE SIGNED (Month, Day, Year): 9/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Qamar Zaman, Memorial HOspital Medical Building, Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 14 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall |

DHMH-16 Rev 1/89

14

89 25779

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ADRIAN MILLER CORBIN | | | 2. DATE OF DEATH (Month - Day - Year): 9 - 13 - 89 | 3. TIME OF DEATH: 1:30 AM |
| 4. SOCIAL SECURITY NUMBER: 220 14 9284 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 1, 1924 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND, MD | | 9c. COUNTY OF DEATH: ALLEGANY |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: WV | 10b. COUNTY: Hampshire | 10c. CITY, TOWN OR LOCATION: Romney | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 70 South Bolton St. | | 10f. ZIP CODE: 26757 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Finishing Dept. | | 16b. KIND OF BUSINESS/INDUSTRY: Westvaco Paper Mfg. |
| 17. FATHER'S NAME (First, Middle, Last): Albert Miller Corbin | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie E. Mayhew | |
| 19a. INFORMANT'S NAME (Type/Print): Joyclyn V. Corbin | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 70 S. Bolton Street, Romney, WV 26757 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Indian Mound Cemetery | | 20c. LOCATION — City or Town, State: Romney, WV |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark L. Shaffer | | 22. NAME AND ADDRESS OF FACILITY: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinomatosis DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Adenocarcinoma of Colon DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D-11443 | ▶ 9/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WAYNE SPIGGLE, M.D., BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 15 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25780

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LUCY CAROLINE CHAPMAN | | | 2. DATE OF DEATH (Month, Day, Year): September 14, 1989 | 3. TIME OF DEATH: 8:15 P M |
| 4. SOCIAL SECURITY NUMBER: 212-38-7435 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): AUGUST 30 1901 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ALLEGANY | 10c. CITY, TOWN OR LOCATION: CUMBERLAND | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 546 NORTH CENTRE STREET | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ALLEGANY CO BOARD OF EDUCATION | 16b. KIND OF BUSINESS/INDUSTRY: FOOD SERVICE -COOK | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM COOPER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): AMY THOMAS | |
| 19a. INFORMANT'S NAME (Type/Print): RONALD E. CHAPMAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RFD# 3 BOX# 135-E BEDFORD ROAD CUMBERLAND MARYLAND 21502 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other): SUNSET MEMORIAL PARK | 20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale L. Merritt | | 22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial Infaction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure., Old age

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D-19750 | 29d. DATE SIGNED (Month, Day, Year): 9/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. V. A. Ranjithan Memorial Hospital Medical Bldg. Cumberland, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): SEP 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25781

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY AMANDA DAYCHAK | | | 2. DATE OF DEATH (Month, Day, Year): September 16, 1989 | 3. TIME OF DEATH: 9:45 A.M |
| 4. SOCIAL SECURITY NUMBER: 214-05-5458 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-20-1913 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 118 Oak Street | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired deputy | | 16b. KIND OF BUSINESS/INDUSTRY: County Tax Office |
| 17. FATHER'S NAME (First, Middle, Last): John H. Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Barkeman | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia Ann Wilson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Fayetteville, NC | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery | | 20c. LOCATION — City or Town, State: Cumberland, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic adenocarcinoma colon. DUE TO (OR AS A CONSEQUENCE OF): | ~4mo. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| ▶ Willem Lamm MD for D Williams | D25406 | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Terry Williams, Memorial Hospital Medical Building, Cumberland, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 19 1989 | Gloria Davidson-Randall |

DNMH-16 Rev 1/89

89 25782

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN ISABELL DORMIO | | | 2. DATE OF DEATH: MONTH 9 DAY 08 YEAR 1989 | 3. TIME OF DEATH: 6:13a M |
| 4. SOCIAL SECURITY NUMBER: 213 24 5469 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8 13 28 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg | | 9c. COUNTY OF DEATH: Allegany |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Frostburg MD | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 326 Allegany St | | 10f. ZIP CODE: 21532 | | 10g. CITIZEN OF WHAT COUNTRY? US |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PAYROLL CLERK | 16b. KIND OF BUSINESS/INDUSTRY: SEARS ROEBUCK & CO. | | |
| 17. FATHER'S NAME (First, Middle, Last): ANNAN R. PRICE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET SHANNON | | |
| 19a. INFORMANT'S NAME (Type/Print): MR. JOHN DORMIO | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 326 ALLEGANY ST., FROSTBURG, MD 21532 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK | 20c. LOCATION — City or Town, State: FROSTBURG, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Miles M. Sowers | 22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD 21532 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Bilateral Pneumonia | 5 day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Neuro - degenerative disease. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Obstructive Sleep Apnoea due to olivo-ponto Cerebellar degeneration i Parkinsons Disease Hypertension - Anxiety - depression

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| S. L. Sandhir MD | D14464 | ▶ 9-8-1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sandhir, S.L. MD 48 Tarn Terrace, Frostburg MD 21532

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 14 1989 | Lidia Davidson-Randall |

ONMN-16 Rev 1/89

89 25783

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PRESTON CALVERT FIX | | 2. DATE OF DEATH: MONTH 9 – DAY 16 – YEAR 89 | 3. TIME OF DEATH: 9:15 AM |
| 4. SOCIAL SECURITY NUMBER: 228 12 3281 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 5, 1920 — 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND, MD | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: LaVale | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 225 National Hwy. | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 5 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dye Design Dept. | 16b. KIND OF BUSINESS/INDUSTRY: Rubber | |
| 17. FATNER'S NAME (First, Middle, Last): Samuel G. Fix | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Nell Snyder | |
| 19a. INFORMANT'S NAME (Type/Print): Juanita S. Fix | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 225 National Hwy. LaVale, MD 21502 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Lawn Mem. Gardens | 20c. LOCATION — City or Town, State: LaVale, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas D. Hafer | | 22. NAME AND ADDRESS OF FACILITY: Hafer Funeral Service 21502, 1302 National Highway, LaVale, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiogenic Shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acute anterior wall MI

DUE TO (OR AS A CONSEQUENCE OF):

c. ASCVD.

DUE TO (OR AS A CONSEQUENCE OF):

d. Smoker (Risk factor).

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NT Non Malignancy suspected, not found

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D-13601 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. RUAL FELIPA, 925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): SEP 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | |

DHMH-16 Rev 1/89

89 25784

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Jonas | Josiah | Johnson | 8 / 31 / 89 | 3:15 P. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-32-3639 | 1 [X] M 2 [ ] F | 53 YRS. | | | 2/11/1936 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Sacred Heart Hospital | Cumberland | Allegany |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Garrett | Grantsville | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Route 1, Box 2, | 21536 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 | | Sawmiller | Saw Mill |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Jonas Harrison Johnson | Anna Fitzpatrick |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary V. Johnson | Rt. 1, Box 2, Grantsville, MD 21536 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Grantsville Cemetery | Grantsville, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Lynn D. Newman | NEWMAN FUNERAL HOMES, P.A. 155 Main Street Grantsville, MD 21536 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell | OCME | ▶ 9-1-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Margarita A. Korell, M.D. | 111 Penn St., Balto., Md. 21201 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 5 89 | Julia Davidson Brandell |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25784

Item:5 per FH G-656
10-30-89 cm

89 25785

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| MARY ELIZABETH VAUGHN MORTZFELDT | September 17, 1989 | 6:30 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-03-7654 | 1 [X] M 2 [ ] F | 68 YRS. | | | Aug. 16, 1921 | W. VA. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Allegany | Cumberland | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 517 Central Avenue | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | Housewife | Domestic |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Wayne Benjamin Lipscomb | Hazel Minnie Morris |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Linda Mortzfeldt | 517 Central Avenue, Cumberland, MD 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Rest Lawn Memorial Gardens | LaVale, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Douglas D. Hafer | Hafer Funeral Service 21502<br>1302 National Hwy. LaVale, MD |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pancreatic carcinoma with liver mets | 8 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [✓] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [✓] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William Lamm MD | D25406 | ▶ 9-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. William D. Lamm 47 Virginia Avenue Cumberland, Md. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 19 1989 | Julia Davidson-Randall |

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DNMN-16 Rev 1/89

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89 25786

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leatta C. McKenzie | | | 2. DATE OF DEATH (Month / Day / Year): 09 13 1989 | 3. TIME OF DEATH: 0228 M |
| 4. SOCIAL SECURITY NUMBER: 213 16 3772 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10 01 1923 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: FRostburg | | 9c. COUNTY OF DEATH: Allegany |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Frostburg | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 2 Box 457 | | 10f. ZIP CODE: 21532 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Downtwist | 16b. KIND OF BUSINESS/INDUSTRY: Textile | |
| 17. FATHER'S NAME (First, Middle, Last): Orvel Crowe | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Leotta Pope | |
| 19a. INFORMANT'S NAME (Type/Print): Clarence M. Mc Kenzie | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 457, Frostburg, Md. 21532 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery | 20c. LOCATION — City or Town, State: Garrett County, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Durst | | 22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cancer of the Right Breast with | Several |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Meta Static Disease to lungs and | months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Multiple places in Bones. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Alzheimers Disease.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Extended Care Unit |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S Lal Sandhir MD | 29c. LICENSE NUMBER: D14464 | 29d. DATE SIGNED (Month, Day, Year): 9-13-89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sandhir, S Lal M.D. 48 Tarn Terrace Frostburg, MD 21532

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 25787

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the [illegible] permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAY WILLIAM PLATTER | | 2. DATE OF DEATH (Month, Day, Year): AUGUST 27, 1989 | 3. TIME OF DEATH: 7:55 A M |
| 4. SOCIAL SECURITY NUMBER: 218248170 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1/30/1925 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: Allegany | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Grantsville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Route 2, Box 67 | 10f. ZIP CODE: 21536 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dam Tender | 16b. KIND OF BUSINESS/INDUSTRY: Savage River Dam | |
| 17. FATHER'S NAME (First, Middle, Last): Austin Ray Platter | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie Fresh | | |
| 19a. INFORMANT'S NAME (Type/Print): Nellie J. Platter | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Box 67; Grantsville, MD 21536 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Grantsville Cemetery | 20c. LOCATION — City or Town, State: Grantsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Lynn Newman | 22. NAME AND ADDRESS OF FACILITY: NEWMAN FUNERAL HOMES, P.A. | 155 Main Street Grantsville, MD 21536 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Coma | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Bilateral cerebral infarctions | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Accelerated Arterial disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Type II Diabetes | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- CAD post MI and Post CABG
- Renal failure due to diabetic Nephropathy
- Chronic active Hepatitis (Non A non B)

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) SHH | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V-R- FELIPA M.D. 925 Bishop Manor Rd Cumberland Md 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): AUG 30 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Pondella |

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DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William David Pauli | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 16, 1989 | 3. TIME OF DEATH: 1240 P.M. M |
| 4. SOCIAL SECURITY NUMBER: 210-34-8959 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 44 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-17-45 | 8. BIRTHPLACE (State or Foreign Country): Penna. |
| 9a. FACILITY NAME (If not institution, give street and number): 230 Braddock Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg | | 9c. COUNTY OF DEATH: Allegany |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Frostburg | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 230 Braddock Road | | | 10f. ZIP CODE: 21532 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist | | 16b. KIND OF BUSINESS/INDUSTRY: National Valve | |
| 17. FATHER'S NAME (First, Middle, Last): William Pauli | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Oliver | | |
| 19a. INFORMANT'S NAME (Type/Print): Phyllis Pauli | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 230 Braddock Road, Frostburg, Md. 21532 | | | |
| 20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Hope Cemetery | | 20c. LOCATION — City or Town, State: Penn Hills, Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Hann | | 22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md. | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Strangulation (asphyxiation) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Victim hung himself | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Manic-depressive personality

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year): 9-12-89 | 28b. TIME OF INJURY: 1130A M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Victim hung himself |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): basement of his home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 230 Braddock Road |

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Snow MD no CX | 29c. LICENSE NUMBER: D09157 | 29d. DATE SIGNED (Month, Day, Year): 9/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow, M.D. Dpty Med. Ex. 124 W. 3rd St., Cumberland, Md. 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 18 1989 | 32. REGISTRAR'S SIGNATURE: Gerald Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25789

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS ABRAHAM PARK | | | | 2. DATE OF DEATH (Month, Day, Year): 09/15/989 | 3. TIME OF DEATH: 11:00A M |
| 4. SOCIAL SECURITY NUMBER: 213105254 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 25, 1908 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Lonaconing | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 100 W. Main St. | | 10f. ZIP CODE: 21539 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Insurance Agent | 16b. KIND OF BUSINESS/INDUSTRY: Insurance | |
| 17. FATHER'S NAME (First, Middle, Last): Abraham Park | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Janet Taylor | |
| 19a. INFORMANT'S NAME (Type/Print): Edna E. Park | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 W. Main St., Lonaconing, Md. 21539 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Laurel Hill Cemetery | 20c. LOCATION — City or Town, State: Moscow Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jas E McKenzie | | 22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiogenic shock & C.H.F. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute MI | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. C.H.D. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/O T.I.A., Pul. Embolism

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C.J. Vincent M.D. | 29c. LICENSE NUMBER: D17474 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. CLARENCE VINCENT 909-B SETON DRIVE CUMBERLAND, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): SEP 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau | |

DHMH-18 Rev 1/89

89 25790

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ORPHIE Unabelle SWEITZER | | | | | 2. DATE OF DEATH (Month, Day, Year): August 18, 1989 | 3. TIME OF DEATH: 10:04 P. |
| 4. SOCIAL SECURITY NUMBER: 220-40-1361 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb. 17, 1922 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Garrett | | 10c. CITY, TOWN OR LOCATION: Swanton | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: Rt. 1, Box 21 | | | 10f. ZIP CODE: 21561 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): George ----- Paugh | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada ----- Uphold | | | |
| 19a. INFORMANT'S NAME (Type/Print): Ruth M. McIntosh | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 21, Swanton, MD 21561 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Cemetery | | 20c. LOCATION — City or Town, State: Swanton, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Braden A. Stewart | | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia / sepsis + multiorgan sys. failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy + congestive heart fail. Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Sagi MD

29c. LICENSE NUMBER: D35481

29d. DATE SIGNED (Month, Day, Year): ▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. James Raver, Memorial hospital, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Pondella

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25791 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CATHERINE A. SHEFFLER | | 2. DATE OF DEATH (Month, Day, Year): September 11, 1989 | 3. TIME OF DEATH: 8:18 P M |
| 4. SOCIAL SECURITY NUMBER: 215-20-6649 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06-11-1904 |
| 8. BIRTHPLACE (State or Foreign Country): MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: Allegany | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 220 Somerville Avenue - Booth Towers | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): etcher | 16b. KIND OF BUSINESS/INDUSTRY: glass factory | |
| 17. FATHER'S NAME (First, Middle, Last): George J. Reitmeier | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Delaney | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Raymond F. Sheffler | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5914 Edna Avenue, Baltimore, MD 21214 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Marys Cemetery | 20c. LOCATION — City or Town, State: Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Adenocarcinoma Ovary

DUE TO (OR AS A CONSEQUENCE OF): (A) Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): C

c. DUE TO (OR AS A CONSEQUENCE OF): C Metastasis

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D16041 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-12-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Terry Williams Memorial Hospital Medical Bldg. Cumberland, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): SEP 14 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Ramsell | |

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DHMH-16 Rev 1/89

89 25792

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ENOS VANSICKLE | | | 2. DATE OF DEATH (Month, Day, Year): September 10, 1989 | 3. TIME OF DEATH: 11:20 A.M |
| 4. SOCIAL SECURITY NUMBER: 210-07-0876 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/15/06 | 8. BIRTHPLACE (State or Foreign Country): Fayette Co. Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUmberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Pa | 10b. COUNTY: Fayette | 10c. CITY, TOWN OR LOCATION: Markleysburg | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: RD#1 Box 224 D | | 10f. ZIP CODE: 15459 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Pa. Dept of Transportation | |
| 17. FATHER'S NAME (First, Middle, Last): Amos VanSickle | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola (Bowlen) VanSickle | |
| 19a. INFORMANT'S NAME (Type/Print): Naomi VanSickle | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD#1 Box 224 D Markleysburg, Pa. 15459 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Thomas Cem. | 20c. LOCATION — City or Town, State: Markleysburg, Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: 010701-L | | 22. NAME AND ADDRESS OF FACILITY: D.R. Crawford Funeral Home PO Box 81 Markleysburg, Pa. 15459 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ABDOMINAL AORTIC ANEURYSM RUPTURE INTO DUODENUM | 1 HOUR |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY
PULMONARY "

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Philip J. Schroeder MD | 29c. LICENSE NUMBER: D17456 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Philip J. Schroeder, Memorial Hospital, Suite 402, Cumberland, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): SEP 19 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25793 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ERNEST WILLIAM BROWN | | | | 2. DATE OF DEATH (Month, Day, Year): 8 30 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-12-7346 | 5. SEX: 1 ☐ M 2 ☐ F XX | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11 24 1918 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 809 Carrollton Ave. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis, Maryland | | 9c. COUNTY OF DEATH: A.A. |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 809 Carrollton Avenue | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced XXX | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: W.W.II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XXX Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY: U.S. NAVAL ACADEMY | |
| 17. FATHER'S NAME (First, Middle, Last): RICHARD W. BROWN | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ESTELLE HENDERSON | | |
| 19a. INFORMANT'S NAME (Type/Print): BEATRICE A. BROWN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 809 Carrollton Ave. Annapolis, Md. 21401 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) XXX | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BREWER HILL CEMETERY | | 20c. LOCATION — City or Town, State: ANNAPOLIS, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II | | 22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A. | | | |

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic prostate cancer | 3 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R.I. Hechman, MD | D5192 | ▶ 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.I. Hechman, MD 16 Murray Ave, Annapolis, Md 21401

31. DATE FILED (Month, Day, Year): SEP 06 1989 — REGISTRAR'S SIGNATURE: for Registrar

DHMH-16 Rev 1/89

68 52133

89 25794

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jeanette M. Cronin | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 12 1989 | 3. TIME OF DEATH: 11:45 PM |
| 4. SOCIAL SECURITY NUMBER: 026-14-8415 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 2, 1923 | 8. BIRTHPLACE (State or Foreign Country): Massachusetts |
| 9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Crofton | | 10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1768 Crofton Parkway | | 10f. ZIP CODE: 21114 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disability Examiner | | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government |
| 17. FATHER'S NAME (First, Middle, Last): George L. Winsor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jean Jamieson | | |
| 19a. INFORMANT'S NAME (Type/Print): Jerome J. Cronin | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Our Lady of the Fields | | 20c. LOCATION — City or Town, State: Millersville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E Evans, Pres. | | 22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | RESPIRATORY FAILURE | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PULMONARY FIBROSIS | YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | TUBERCULOSIS AND | YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | THORACOPLASTY | YEARS |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS
MALABSORPTION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D19991 | 29d. DATE SIGNED (Month, Day, Year): 9/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID RISE, M.D. SUITE 500 200 HOSPITAL DRIVE GLEN BURNIE MD

31. DATE FILED (Month, Day, Year): SEP 14 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25795

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for the records of attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH J DEEMS | | | | 2. DATE OF DEATH (Month, Day, Year): 08 31 89 | 3. TIME OF DEATH: 100 PM M |
| 4. SOCIAL SECURITY NUMBER: 205-22-4916 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): April 10, 1911 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 700 Hamlen Rd. | | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Ralph Courtley | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabella U/K | | |
| 19a. INFORMANT'S NAME (Type/Print): Carrie M. Zaukus | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Hamlen Rd., Glen Burnie, MD 21061 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | 20c. LOCATION — City or Town, State: Glen Burnie, A.A., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Synergistic Gangrene | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. occlusion, Left iliac artery | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Arteriosclerosis Obliterans | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D08609 | ▶ 9/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARTHUR L. GUDWIN, M.D. 7310 RITCHIE HIGHWAY, SUITE 500 GLEN BURNIE, MARYLAND 210

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 01 1989 | [signature] |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25796 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LELIA S. EBERLY
2. DATE OF DEATH — MONTH: 9 DAY: 3 YEAR: 89
3. TIME OF DEATH: 3 25 M
4. SOCIAL SECURITY NUMBER: 577 40 1348
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-27-01
8. BIRTHPLACE (State or Foreign Country): West Va
9a. FACILITY NAME (If not institution, give street and number): A.A. Med. Cen.
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: A.A.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: A.A.
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2658 Quiet Water Cove
10f. ZIP CODE: 21144
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5 +): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary/Book Keeper
16b. KIND OF BUSINESS/INDUSTRY: Plumbing/Heating
17. FATHER'S NAME (First, Middle, Last): Anthony M. Staubly
18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie A. Drenner
19a. INFORMANT'S NAME (Type/Print): Hengry Eberly
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 621 Beach Dr.,Annapolis,Md.21403
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery
20c. LOCATION — City or Town, State: Suitland,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Md. 20735

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction — Approximate Interval: 2 hours
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ew Cole MD
29c. LICENSE NUMBER: D16354
29d. DATE SIGNED (Month, Day, Year): ▶ 9/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 51 FRANKLIN ST ANNAP Md 21401
31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25797

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bernard, Evans | | | 2. DATE OF DEATH: Month 9, Day 2, Year 89 | 3. TIME OF DEATH: 1425 M |
| 4. SOCIAL SECURITY NUMBER: 086-18-6954 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6/27/24 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Med Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annap Md | | 9c. COUNTY OF DEATH: AA |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Gambrills, MD | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2045 Hermitage Hills Drive | | 10f. ZIP CODE: 21054 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5 + | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer | | 16b. KIND OF BUSINESS/INDUSTRY: Construction |
| 17. FATHER'S NAME (First, Middle, Last): Martin Evans | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Freida Myers | | |
| 19a. INFORMANT'S NAME (Type/Print): Marian G. Evans | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2045 Hermitage Hills Drive, Gambrills, MD 21054 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | | 20c. LOCATION — City or Town, State: Annapolis, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert L. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ventricular Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic lung disease

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO Consulted | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rodney L. Borinhall MD | 29c. LICENSE NUMBER: DO 1846 Md. | 29d. DATE SIGNED (Month, Day, Year): 9/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.L. Borinhall MD 1833 Forest Dr. Annapolis Md. 21401 | | |
| 31. DATE FILED (Month, Day, Year): SEP 06 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page ___ may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LENA MARIE FLORESTANO | | | 2. DATE OF DEATH (Month, Day, Year): Sept 4, 1989 | 3. TIME OF DEATH: 2:23 P M |
| 4. SOCIAL SECURITY NUMBER: 218-42-5051 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 5, 1900 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): PEASANT Living Conv Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater | | 9c. COUNTY OF DEATH: Anne Arundel |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Edgewater | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 144 Washington Road | | 10f. ZIP CODE: 21037 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Lorea | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Concetta Camella | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas E. Florestano | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1516 Farlow Avenue, Crofton, MD 21114 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure — DUE TO (OR AS A CONSEQUENCE OF): — years

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): — many years
c. — DUE TO (OR AS A CONSEQUENCE OF):
d. —

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
-Peptic Ulcer disease & bleeding - recurrent
-Advanced Age - Blindness.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter F. VerKouw MD | 29c. LICENSE NUMBER: D 11653 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-5-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter F. VERKOUW, 1833 Forest Drive, Annapolis, Md 21401 | | |
| 31. DATE FILED (Month, Day, Year): SEP 06 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25799

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANKLIN A. GREEN | | 2. DATE OF DEATH (Month, Day, Year): 9 2 89 | 3. TIME OF DEATH: 11:00 P M |
| 4. SOCIAL SECURITY NUMBER: 219-28-5131 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 4 15 1932 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2048 Gate Court | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): GREENS KEEPER | 16b. KIND OF BUSINESS/INDUSTRY: EISENHOUSER GOLF COURSE | |
| 17. FATHER'S NAME (First, Middle, Last): REV. CHARLES A. GREEN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BEATRICE ANDERSON | | |
| 19a. INFORMANT'S NAME (Type/Print): MARY C. GREEN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2048 Gate Court Annapolis, Md. 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ASBURY BROADNECK CHURCH CEME. | 20c. LOCATION — City or Town, State: St. Margarets, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry G. Reese | 22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md 21401 WILLIAM REESE & SONS MORTUARY, P.A. | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lung Cancer | 1½ Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Stuart E. Jelonick, MD | 019838 | ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 51 Franklin St Annapolis, Md. 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 06 1989 | Julia Davidson Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25800
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death and signed by the hos... attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached ... use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CLARENCE EDWIN GUY | | | | 2. DATE OF DEATH (Month, Day, Year): 09 02 89 | 3. TIME OF DEATH: 2020 M |
| 4. SOCIAL SECURITY NUMBER: 214-18-7652 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 01-15-23 |
| 8. BIRTHPLACE (State or Foreign Country): Annapolis, MD | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 605 BESTGATE Rd. | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elemantary/Secondary (0-12): 10 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): chauffer | | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): THOMAS C. GUY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SADIE M. FRAZIER | |
| 19a. INFORMANT'S NAME (Type/Print): JESSICA S. GUY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 BESTGATE ROAD, ANNAPOLIS, MD 21401 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HILLCREST CEMETERY | | 20c. LOCATION — City or Town, State: ANNAPOLIS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ball D Arndt | | 22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME 12 RIDGELY AVE. Annapolis, MD | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Dilated cardiomyopathy | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertension | several years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer MD | 29c. LICENSE NUMBER: D05928 | 29d. DATE SIGNED (Month, Day, Year): Sept. 3, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Kinzer, M.D. 1833A Forest Drive, Annapolis, MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): SEP 06 1989 | 32. REGISTRAR'S SIGNATURE: Trisha Davidson-Kendall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25801

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FERN Bell L'AIGLE | | 2. DATE OF DEATH (Month, Day, Year): 09 05 89 | 3. TIME OF DEATH: 0356 M |
| 4. SOCIAL SECURITY NUMBER: 214-05-2468A | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 07-28-18 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GEN HOSP & MEDICAL CTR | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS, MD 21401 | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3 TYLER PLACE | 10f. ZIP CODE: 21403 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Norman R. Bell, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Stevens | |
| 19a. INFORMANT'S NAME (Type/Print): Marshall A. L'Aigle | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Tyler Place, Annapolis, MD 21403 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Anne's Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel, 147 Gloucester St., Annapolis, MD 21401 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. HASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Vasculitis, Hypertension
Obesity
Ca (Breast)

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. Sfakianos MD | 29c. LICENSE NUMBER: D 21438 | 29d. DATE SIGNED (Month, Day, Year): ▶ 09.05.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL J. SFAKIANOS MD 703 GILDINGS AVE ANNAPOLIS MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): SEP 06 1989 | 32. REGISTRAR'S SIGNATURE: Jeanette Chamberlain-Kennedy | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stanley Roger Kane
2. DATE OF DEATH (Month, Day, Year): 9 13 89
3. TIME OF DEATH: 3 20 A M
4. SOCIAL SECURITY NUMBER: 578-10-5143
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-26-06
8. BIRTHPLACE (State or Foreign Country): Connecticut
9a. FACILITY NAME (If not institution, give street and number): Crofton Conv. Center
9b. CITY, TOWN OR LOCATION OF DEATH: Crofton Md
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Ann Arundel
10c. CITY, TOWN OR LOCATION: Crofton
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2131 Davidsonville Road
10f. ZIP CODE: 21114
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Upholster
16b. KIND OF BUSINESS/INDUSTRY: D.C. Transit Co.
17. FATHER'S NAME (First, Middle, Last): William Kane
16. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Skinner
19a. INFORMANT'S NAME (Type/Print): Katherine Patton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1536 Farlow Ave. Crofton, MD 21114
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill
20c. LOCATION — City or Town, State: Suitland, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dave A Wilhelm
22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD. 20746

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardio-Respiratory Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Chronic Renal Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): c. | Diabetes Mellitus | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation; Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lenny Cavanaugh MD
29c. LICENSE NUMBER: 031602
29d. DATE SIGNED (Month, Day, Year): 9/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3 Village Greene Crofton, Md 21114
31. DATE FILED (Month, Day, Year): SEP 15 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Catherine V. Kerns
2. DATE OF DEATH — MONTH: 8 DAY: 29 YEAR: 89
3. TIME OF DEATH: 1:45 P.M.
4. SOCIAL SECURITY NUMBER: 579-01-3138
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-29-19
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): A.A.M.C.
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: A.A.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: A.A.
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 933 Riversedge Circle
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondery (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Phone Operator
16b. KIND OF BUSINESS/INDUSTRY: The Washington Post
17. FATHER'S NAME (First, Middle, Last): William T. Meushaw
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith May Dingee
19a. INFORMANT'S NAME (Type/Print): J. Nicholis Manthos
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 A Governors Bridge Road, Davidsonville, Md. 21035
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery
20c. LOCATION — City or Town, State: Suitland, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ca of lung = metastases.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes.
Coronary Artery Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Rodney L. Brimhall M.D.
29c. LICENSE NUMBER: DO 1846 Md.
29d. DATE SIGNED (Month, Day, Year): 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.L. Brimhall M.D. 1833 Forest Dr. Annapolis Md. 21401
31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25804
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| DANIEL | G. | McDONALD, SR. | 9 / 1 / 1989 | 10:45A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-60-1396 | 1 [X] M 2 [ ] F | 37 YRS. | | | 2-24-52 | FL |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| North Arundel Hospital (DOA) | Glen Burnie | Anne Arundel |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | Baltimore | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1514 Hazel Street | 21226 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Vietnam | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Maintenence | State Highway Administration |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Herbert L. Mc Donald | Wilmetta M. Jenkins |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sharon A. Mc Donald | Same as # 10 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Glen Haven Memorial Park | Glen Burnie, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Barranco Severna Park, MD 21146 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Head and chest injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 9-1-89 | M | 1 [X] YES 2 [ ] NO | Pedestrian struck by truck |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| road | Rt. 2 & Rt. 100, Anne Arundel Co., MD |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | OCME | ▶ 9-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 06 1989 | [signature] |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Pages ... must be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral ... should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES L. NIEBERLEIN | | 2. DATE OF DEATH (Month, Day, Year): SEPT 3 1989 | 3. TIME OF DEATH: A M |
| 4. SOCIAL SECURITY NUMBER: 521 58 4801 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV 25 1944 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 947 MARINE DR. | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS MD | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS MARYLAND | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 947 MARINE DR. | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CIVIL ENGINEER | 16b. KIND OF BUSINESS/INDUSTRY: PUBLIC WORKS A.A. COUNTY |
| 17. FATHER'S NAME (First, Middle, Last): NORMAN W. NIEBERLEIN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DOROTHY O'CONNOR | |
| 19a. INFORMANT'S NAME (Type/Print): PATRICIA A. NIEBERLEIN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 947 MARINE DR. ANNAPOLIS MD. 21401 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN SERVICE | 20c. LOCATION — City or Town, State: ALEX. VA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald L Fyfe | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel Annapolis, Md | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Malignant Melanoma | one year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S.E. Killian M.D. | 29c. LICENSE NUMBER: D29193 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.E. Killian M.D 2525 Riva Rd., Annapolis, Md. 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 9/3/8 SEP 06 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Owens, MARGARET MARGARET OWENS
2. DATE OF DEATH — MONTH: 8 DAY: 30 YEAR: 89
3. TIME OF DEATH: 4 25 P M
4. SOCIAL SECURITY NUMBER: 218-12-9652
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5 30 1922
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS MD
9c. COUNTY OF DEATH: AA

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: ANNAPOLIS
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 2124 Mulberry Hill Rd.
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 XXX Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XXX IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): OLIVER THOMAS
18. MOTNER'S NAME (First, Middle, Maiden Surname): MARGARET HUNT
19a. INFORMANT'S NAME (Type/Print): RHONDA GREEN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2124 Mulbery Hill Rd. Annapolis, Md. 21401
20a. METNOD OF DISPOSITION: 1 XXX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other piece): ASBURY BROADNECK CEMETERY
20c. LOCATION — City or Town, State: St. Margarets, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William Reese, II
22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF): INFECTED SACRAL DECUBITUS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☑ NO
28. PLACE OF OEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. OESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald C. Roore M.D.
29c. LICENSE NUMBER: D10698
29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): DONALD C. ROORE M.D. 1616 FOREST DRIVE ANNAPOLIS 21403
31. DATE FILED (Month, Day, Year)
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with... may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by... page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal...
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25807

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): KATHERINE V SHERBERT | | | 2. DATE OF DEATH (Month, Day, Year): 09 01 89 | 3. TIME OF DEATH: 7:55 P M |
| 4. SOCIAL SECURITY NUMBER: 217-40-0927 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07/08/08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 67 College Avenue | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): George M. Sherbert | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Virginia Rogers | | |
| 19a. INFORMANT'S NAME (Type/Print): Louis N. Phipps, Jr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 826 Bywater Road, Annapolis, MD 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sherbert Family Cemetery | 20c. LOCATION — City or Town, State: Deale, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | ACUTE |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. URINARY TRACT INFECTION | ?DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ADVANCED DEMENTIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Barry R. Nathanson MD | 29c. LICENSE NUMBER: D23454 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARRY R. NATHANSON M.D. 51 FRANKLIN ST. ANNAPOLIS, MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 06 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25808 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Items may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS WELDON WILLS SR | | | 2. DATE OF DEATH (Month / Day / Year): 08 29 89 | 3. TIME OF DEATH: 600 PM M | |
| 4. SOCIAL SECURITY NUMBER: 579-20-0962 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9 24 1922 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | 9c. COUNTY OF DEATH: A.A. COUNTY | | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: SEVERN | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO | | |
| 10e. STREET AND NUMBER: 1675 Circle Rd. Apt. 368 | | 10f. ZIP CODE: 21144 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W.II | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAINTANCE | 16b. KIND OF BUSINESS/INDUSTRY: A.A. COUNTY HOUSING AUTH. | | |
| 17. FATHER'S NAME (First, Middle, Last): DAVID WILLS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BARBARA WILLS | | | |
| 19a. INFORMANT'S NAME (Type/Print): ELEANOR BUTLER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1675 Circle Rd. Apt. 368 Severn, MD. 21144 | | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERAN CEME. | 20c. LOCATION — City or Town, State: CROWNSVILLE, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William Reese, II | | 22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A. | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Malignant Tumor small bowel | 3 mths. |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Congestive Heart Failure | 14 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R Karipenni MD | D2307 | 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. KARIPENNI, M.D. 337 HOSPITAL DRIVE GLEN BURNIE MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 06 1989 | Julia Davidson Rhodes |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25809 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Nellie Franklin Diggins | | | | 2. DATE OF DEATH (Month, Day, Year): 9 14 89 | 3. TIME OF DEATH: 12:15 AM |
| 4. SOCIAL SECURITY NUMBER: 214-05-5281 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-14-09 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore Co. General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3687 Forest Hill Road | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fort Cumberland Hotel | 16b. KIND OF BUSINESS/INDUSTRY: Hotel | |
| 17. FATHER'S NAME (First, Middle, Last): John Louis Franklin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Jackson | |
| 19a. INFORMANT'S NAME (Type/Print): Spurgeon Washington, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3687 Forest Hill Rd. Baltimore, Md. 21207 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Cumberland, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest A. Riley, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Leasure-Stein Funeral Home 230 Baltimore Ave. Cumberland, Md. 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Urosepsis DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☑ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ed Pkacnik MD | 29c. LICENSE NUMBER: D34151 | 29d. DATE SIGNED (Month, Day, Year): ▶ |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ED PKACNIK MD Balt County General Hosp | | |
| 31. DATE FILED (Month, Day, Year): SEP 18 1989 | 32. REGISTRAR'S SIGNATURE: Judy Davidson-Rowe | |

DHMH-16 Rev 1/89

Item 4 9-20-89 Film G655 W.H. Per F/H

89 25810

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frank J. Kulski | | | | 2. DATE OF DEATH (Month, Day, Year): Aug. 28, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-01-0871 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09/01/99 | 8. BIRTHPLACE (State or Foreign Country): Poland |
| 9a. FACILITY NAME (If not institution, give street and number): 1110 Elmridge Avenue | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Arbutus | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1110 Elmridge Avenue | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: NA | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+) | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): technician | 16b. KIND OF BUSINESS/INDUSTRY: factory |
| 17. FATHER'S NAME (First, Middle, Last): Anthony Kulski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances | |
| 19a. INFORMANT'S NAME (Type/Print): G. Gertrude Kulski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1110 Elmridge Avenue Arbutus Md 21229 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cemetery | 20c. LOCATION — City or Town, State: Dundalk, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD, ARBUTUS, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Vascular Insufficiency | 1 h |
| DUE TO (OR AS A CONSEQUENCE OF): | ASCVD | 20 y |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D590 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] | | |
| 31. DATE FILED (Month, Day, Year): 8/29/89 | 32. REGISTRAR'S SIGNATURE: AUG 30 '89 [signature] | |

DHMH-18 Rev 1/89

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Item 8 9-20-89 Film G655 W.H. Per F/H

89 25811

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25811

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached if used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Davis G. Nicholson | | 2. DATE OF DEATH (Month, Day, Year): 09 02 89 | 3. TIME OF DEATH: 6:45 PM |
| 4. SOCIAL SECURITY NUMBER: 214 12 0959 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): 05 02 11 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSP | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: Sykesville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7521 Gaither Rd | 10f. ZIP CODE: 21784 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter | 16b. KIND OF BUSINESS/INDUSTRY: Building | |
| 17. FATHER'S NAME (First, Middle, Last): George H. Nicholson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ackie Corbin | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Smith | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3780 Roop Rd. New Windsor Md 21776 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Mem. Park | 20c. LOCATION — City or Town, State: Sykesville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) SYKESVILLE, MD 21784 (301)-795-1400 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE CEREBROVASCULAR ACCIDENT | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. TESTICULAR CANCER | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William L Yap MD | 29c. LICENSE NUMBER: D31256 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM L. YAP MD BALTIMORE COUNTY GENERAL HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): SEP 5, '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

UNKNOWN 89-122

89 25812

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Billy Arthur Peterson | | 2. DATE OF DEATH (Month, Day, Year): 8-5-89 | 3. TIME OF DEATH: 5:00AM M |
| 4. SOCIAL SECURITY NUMBER: 239-68-1199 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 47 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): JUNE 7,1942 | 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA | | |
| 9a. FACILITY NAME (If not institution, give street and number): Ballfield behing Boys Club | 9b. CITY, TOWN OR LOCATION OF DEATH: Fuselage Rd.,Essex | 9c. COUNTY OF DEATH: Baltimore Co. | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: MIDDLE RIVER | 10d. INSIDE CITY LIMITS? 1 ☐ YES XX NO |
| 10e. STREET AND NUMBER: DIHEDRAL DRIVE | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: JAN 1961-DEC 1964 | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DRIVER | 16b. KIND OF BUSINESS/INDUSTRY: TRUCKING COMPANY | |
| 17. FATHER'S NAME (First, Middle, Last): JOSH PETERSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EVA McCURRY | | |
| 19a. INFORMANT'S NAME (Type/Print): JOSEPH M. PETERSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 CHURCH STREET, CAMBRIDGE, MD 21613 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD EASTERN SHORE VETERANS CEM. | 20c. LOCATION — City or Town, State: BEULAH, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard D. Zeller | 22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME EAST NEW MARKET, MD 21631 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple blunt force injuries to head and neck with asphyxiation

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence XX Other (Specify): Scene | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XX Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8-5-89 | 28b. TIME OF INJURY: 12:30A | 28c. INJURY AT WORK? 1 ☐ YES XX NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Subject beaten | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): ballfield | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Boys Club,Fuselage Rd.Essex, Baltimore County, Maryland | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 8-5-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,Jr.,M.D. | 111 Penn Street,Baltimore,MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): SEP - 5 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25813
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ludelia A. SAULTERS | | | 2. DATE OF DEATH (Month, Day, Year): September 1, 1989 | 3. TIME OF DEATH: 1:25 pM |
| 4. SOCIAL SECURITY NUMBER: 247-08-3490 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 30 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-8-1959 |
| 8. BIRTHPLACE (State or Foreign Country): S.C. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Essex | 9c. COUNTY OF DEATH: Baltimore County | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Aberdeen Proving Ground | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2781 Halbord Crt. | 10f. ZIP CODE: 21005 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: Active Duty | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 6+): ------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Soldier | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Army | |
| 17. FATHER'S NAME (First, Middle, Last): Roosevelt Thomas | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ALMADA THOMAS | | |
| 19a. INFORMANT'S NAME (Type/Print): Bruce Saulters | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2781 Halbord Crt. Aberdeen Proving Ground, MD. 21005 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOUSE OF PRAYER CEMETERY | 20c. LOCATION — City or Town, State: GEORGETOWN, S. CAROLINA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers #670 | 22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory srrest, shock, or heert failure. List only one csuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Probable Acute Bronchopneumonia.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if sny, leading to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST

b. Multiple Organ failure (Kidney, Liver, Lung)

DUE TO (OR AS A CONSEQUENCE OF):

c. Hypotension/Shock.

DUE TO (OR AS A CONSEQUENCE OF):

d. Toxemia of Pregnancy.

PART II. Other significent conditions contributing to death but not resulting in the underlying csuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: P.L. Farmer M.D. | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 9-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Pamela Farmer MD. 9000 Franklin Square Drive Balto, Md. 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BRITTANY DAUGHERTY — Brittany Nichole Daugherty | | | 2. DATE OF DEATH (Month, Day, Year): 09 02 89 | 3. TIME OF DEATH: 4:15 PM |
| 4. SOCIAL SECURITY NUMBER: | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (If yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS DAYS 13 — IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/20/89 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md. | | 9c. COUNTY OF DEATH: ~~Baltimore~~ |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: Patapsco | 10c. CITY, TOWN OR LOCATION: Finksburg | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3233 Murray Rd. | | 10f. ZIP CODE: 21048 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Freeman Daugherty | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julee Lynn Mingee | | |
| 19a. INFORMANT'S NAME (Type/Print): Freeman J. Daugherty Je. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3233 Murray Rd. #15, Finksburg, Md. 21048 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery | | 20c. LOCATION — City or Town, State: Clinton, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joan F. Huntt | | 22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P.O. Box 156, Waldorf, Md. 20646 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METABOLIC + RESPIRATORY ACIDOSIS | 4 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. RENAL FAILURE | 4 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. PULMONARY INSUFFICIENCY | 13 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. PREMATURITY | 13 DAYS |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Peter C. Adamson MD | D-37544 | ▶ 09/02/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER C. ADAMSON, FRANCIS SCOTT KEY MEDICAL CENTER

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 06 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25815

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Michael J. Dell'Erba | | | 2. DATE OF DEATH (Month, Day, Year): 9-4-89 | 3. TIME OF DEATH: 6:25PM M |
| 4. SOCIAL SECURITY NUMBER: 220-60- 7436 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 9, 1953 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: New Carrollton | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6602 Rycroft Street | | 10f. ZIP CODE: 20784 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Vietnam | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 8+): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Paint Contractor | 16b. KIND OF BUSINESS/INDUSTRY: Self Employed | | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Dell'Erba | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida De Cerbo | | |
| 19a. INFORMANT'S NAME (Type/Print): Frank Dell'Erba | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6602 Rycroft Street, New Carrollton, Md. 20784 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery | 20c. LOCATION — City or Town, State: Cheltenham, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clark E Wilson | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hampshire Ave., S.S. Md. 20904 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Complications of Multiple Injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [ ] YES [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): Ukn. | 28b. TIME OF INJURY: ukn. M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Victim in motorcycle accident | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): unknown | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Anne Arundel County, Maryland | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-5-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

3

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IRENE Morse LILLEY | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 1, 1989 | 3. TIME OF DEATH: 3:22 A M |
| 4. SOCIAL SECURITY NUMBER: 217-32-4991 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): June 9, 1913 |
| 8. BIRTHPLACE (State or Foreign Country): Washington, D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery County | 10c. CITY, TOWN OR LOCATION: Takoma Park | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1000 Hopewell Avenue | 10f. ZIP CODE: 20912 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Electrical Contractor | |
| 17. FATHER'S NAME (First, Middle, Last): James Taylor | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Olivia Pixton | | |
| 19a. INFORMANT'S NAME (Type/Print): Norman J. Lilley (Son) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14126 Old Columbia Pike Burtonsville, Md. 20866 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | 20c. LOCATION — City or Town, State: Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark G Brohan | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Chronic Obstructive Pulmonary Disease | 5 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: tracheo-esophageal fistula

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Covinsky, Johns Hopkins Hospital, Department of Medicine

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 23816

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25817

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BABY GIRL A LIEBERT | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 19, 1989 | 3. TIME OF DEATH: 7:58A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 0 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08/19/89 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2500 A WENTWORTH RD | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): LIEBERT, JEFFREY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LAUREN STUDMAN | |
| 19a. INFORMANT'S NAME (Type/Print): TERRY DAVIS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 N. WOLFE ST BALTIMORE, MD. 21205 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JHH/DISPOSAL | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Candida Albicans Sepsis | 27 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Right Atrial Thrombus | 5 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Chronic Lung Disease | 31 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | Prematurity | 31 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephanie Burns, MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephanie Burns, Johns Hopkins Hospital, 600 N. Wolfe St, Baltimore, MD 21205

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 25 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson Rowland |

DHMH-18 Rev 1/89

89 25817

89 25818

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas Francis Murray | | 2. DATE OF DEATH (Month, Day, Year): 9 8 89 | 3. TIME OF DEATH: 6:2 PM |
| 4. SOCIAL SECURITY NUMBER: 093348336 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/30/43 |
| 8. BIRTHPLACE (State or Foreign Country): New York | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Fallston | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 342 Old Joppa Road | 10f. ZIP CODE: 21047 | 10g. CITIZEN OF WHAT COUNTRY: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Social Worker | 16b. KIND OF BUSINESS/INDUSTRY: Md. State Dept. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Francis Michael Murray | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Catherine Fischer |
| 19a. INFORMANT'S NAME (Type/Print): Francis M. Murray | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 342 Old Joppa Road, Fallston, Md. 21047 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery | 20c. LOCATION — City or Town, State: Bel Air, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III | 22. NAME AND ADDRESS OF FACILITY: Howard K.McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon,Md. 21009 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceusad the death. Do not entar tha mode of dying, such ea cardiac or reapiretory arrest, shock, or hasrt failure. List only one cause on each line. — Approximate Interval Between Onset and Daath

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. adult Immune Deficient syndrome
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter Chagares House Staff | 29c. LICENSE NUMBER: D37777 | 29d. DATE SIGNED (Month, Day, Year): 9/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 301 S7 PAUL PLACE BALTIMORE

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25819

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): KATHLEEN M. MCGLONE | | | 2. DATE OF DEATH (Month, Day, Year): AUGUST 19, 1989 | 3. TIME OF DEATH: 8:50 P |
| 4. SOCIAL SECURITY NUMBER: 191 38 6996 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 42 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03-19-1947 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: PA | 10b. COUNTY: Chester | 10c. CITY, TOWN OR LOCATION: West Chester | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1200 Estate Drive | 10f. ZIP CODE: 19380 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO X — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive Director | 16b. KIND OF BUSINESS/INDUSTRY: College Fraterinty |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John V. Hendrick, Jr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice M. Gallagher |
| 19a. INFORMANT'S NAME (Type/Print): Gerard J. McClone, Sr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1200 Estate Drive, West Chester, PA 19380 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Agnes Cemetery | 20c. LOCATION — City or Town, State: West Chester, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William S. Smith, II #M00545 | 22. NAME AND ADDRESS OF FACILITY: Reilly & DellaVecchia Fnl Home, Inc West Chester, PA 19380 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC ASYSTOLE | 2 minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | VENTRICULAR FIBRILLATION | 2 minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | BRAINSTEM DYSFUNCTION/HYPOTENSION | 4½ hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | CHRONIC MYELOGENOUS LEUKEMIA | 3 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Patient was 15 days status post ablation chemotherapy and allogeneic bone marrow transplantation, following a preparative regimen of irradiation & cyclophosphamide

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8/19/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jeffrey J Stoddard MD | 29c. LICENSE NUMBER: A9566 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JEFFREY J STODDARD, MD 600 N WOLFE ST BALTIMORE MD 21205

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 8/19/89 | 32. REGISTRAR'S SIGNATURE: AUG 21 '89 Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED NON-MED PER MR. CURZI/DR. KAPLAN

Item 6 9-18-89 Film G655 W.H.

89 25820

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Charles R. McGowan
2. DATE OF DEATH (Month, Day, Year): 8-29-89
3. TIME OF DEATH: 1:18AM M
4. SOCIAL SECURITY NUMBER: 217-52-9588
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 40 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 2/26/48
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 814 McAleer Ct.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Furniture Mover
16b. KIND OF BUSINESS/INDUSTRY: Moving Co.
17. FATHER'S NAME (First, Middle, Last): James McGowan
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula McGowan
19a. INFORMANT'S NAME (Type/Print):
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery 9/1/89
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Rodney S. Sykes
22. NAME AND ADDRESS OF FACILITY: Rodney S. Sykes Funeral Service 4616 Liberty Heights Ave. 21207

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute coronary thrombosis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,Jr.,MD 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 13 1989
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial or removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ITEM: 23 per ME G-660 2-9-90 cm
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 52850

4

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25821

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NAPOLILLO, Angela | | | | 2. DATE OF DEATH: MONTH SEPT. DAY 11 YEAR 89 | 3. TIME OF DEATH: 11:51 AM |
| 4. SOCIAL SECURITY NUMBER: 156-34-7619 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-9-07 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD. | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 316 S. EXETER ST. | | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): FRANK NAPOLILLO | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY CONCETTA MARIELLA |
| 19a. INFORMANT'S NAME (Type/Print): GIA BLATTERMAN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 S. EXETER ST. |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CEM. | 20c. LOCATION — City or Town, State: BALTIMORE MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: [illegible] 21202 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumonia | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | COPD / C.H.F. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Tony Hsiao M.D. | 29c. LICENSE NUMBER: Resident | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mercy Hospital 301 St. Paul Pl. | | |
| 31. DATE FILED (Month, Day, Year): SEP 19 89 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

88 52051

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25822

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVELYN E. WAGNER | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 15, 1989 | 3. TIME OF DEATH: 8:25A M |
| 4. SOCIAL SECURITY NUMBER: 080 18 1431 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 12, 1924 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Joppatown | 10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 424 Trimble Rd. | 10f. ZIP CODE: 21085 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Earl Stotler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Letitia P. Ritz |
| 19a. INFORMANT'S NAME (Type/Print): Wayne Wagner, Son | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 College Ave. Lutherville, Md. 21093 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Baltimore Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION | 4 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY Artery disease | 10 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Vincent J. Pompili, M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Vincent J. Pompili M.D. 600 N Wolfe Street, Baltimore MD 21205 | | |
| 31. DATE FILED (Month, Day, Year): SEP 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-10 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25823

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Vincent Mitchel Buckler | | 2. DATE OF DEATH (Month / Day / Year): 9 / 2 / 1989 | 3. TIME OF DEATH: 0505 AM |
| 4. SOCIAL SECURITY NUMBER: 214-16-8929 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6/25/1919 |
| 8. BIRTHPLACE (State or Foreign Country): Hughesville MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick, MD | 9c. COUNTY OF DEATH: Calvert | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: St. Mary's | 10c. CITY, TOWN OR LOCATION: Hughesville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 118 Teagues Point Rd. | 10f. ZIP CODE: 20637 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11GR; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Agriculture | |
| 17. FATHER'S NAME (First, Middle, Last): William Buckler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Muriel Buckler | | |
| 19a. INFORMANT'S NAME (Type/Print): Norma L. Buckler | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 Teagues Point Rd., Hughesville, MD 20637 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery | 20c. LOCATION — City or Town, State: Bryantown, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward G. Mudd | 22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, MD 20604 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADENOCARCINOMA OF JEJUNUM | 2 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. WITH METASTASIS. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A T Munshi M.D. | 29c. LICENSE NUMBER: D 19427 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anwar Munshi M.D. Prince Frederick, Md. 20678

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 06 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

88 52853

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25824 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Genevieve L. Lolly DOVE Dove (Genivieve) | | | | 2. DATE OF DEATH: Month 09 Day 12 Year 89 | 3. TIME OF DEATH: 11:55 PM |
| 4. SOCIAL SECURITY NUMBER: 213 74 7790 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 11, 1903 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Calvert Co. Nursing Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick | | 9c. COUNTY OF DEATH: Calvert |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Calvert | 10c. CITY, TOWN OR LOCATION: Broomes Island | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Nans Cove Road | | 10f. ZIP CODE: 20615 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife | 16b. KIND OF BUSINESS/INDUSTRY: homemaker | |
| 17. FATHER'S NAME (First, Middle, Last): J. Frank Elliott | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie V. Grierson | |
| 19a. INFORMANT'S NAME (Type/Print): Norman E. Dove | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4058 Nans Cove ROad Broomes Island Md 20615 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Broomes Island Wesleyan Cemetery | 20c. LOCATION — City or Town, State: Broomes Island Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ BRausch | 22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home 4405 Broomes Island ROad Port Republic MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BRAINSTEM CEREBROVASCULAR ACCIDENT | 2days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. GENERALIZED ANASARCA | 2days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): — | 28b. TIME OF INJURY: — M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): — | | 28d. DESCRIBE HOW INJURY OCCURED: — |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): — |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D-25519 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-13-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

Item:28b read blank per ME G-656
10-27-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25825 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Kevin James Langley

**2. DATE OF DEATH** (Month, Day, Year): 9-7-89

**3. TIME OF DEATH**: 4:00PM M

**4. SOCIAL SECURITY NUMBER**: 213 84 5229

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 26 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 9 29 62

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): Patuxent Avenue

**9b. CITY, TOWN OR LOCATION OF DEATH**: Broomes Island

**9c. COUNTY OF DEATH**: Calvert County

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Calvert

**10c. CITY, TOWN OR LOCATION**: St. Leonard

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: P.O. Box3

**10f. ZIP CODE**: 20685

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: white

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4 or 5+): n/a

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): carpenter

**16b. KIND OF BUSINESS/INDUSTRY**: new construction

**17. FATHER'S NAME** (First, Middle, Last): Lee M Langley

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Lani Hiukle

**19a. INFORMANT'S NAME** (Type/Print): Lee M. Langley

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 93 Solomons Md. 20688

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Solomons U.M. Church Cemetery

**20c. LOCATION — City or Town, State**: Solomons Maryland 20688

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: B Rausch

**22. NAME AND ADDRESS OF FACILITY**: Rausch Funeral Home
4405 Broomes Island Rd. Port Republic,Md 20676

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gunshot wound of chest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** [X] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** [X] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [X] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify): Scene

**27. MANNER OF DEATH**: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): 9-7-89

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [X] NO

**28d. DESCRIBE HOW INJURY OCCURED**: Subject shot

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify): house

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): Petaxen Avenue,Broomes Island, Calvert County, Maryland

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Margarita Brethell

**29c. LICENSE NUMBER**: OCME

**29d. DATE SIGNED** (Month, Day, Year): 9-7-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 vc

**31. DATE FILED** (Month, Day, Year): SEP 12 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

88 52852

89 25826

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles James Watkins | | | | 2. DATE OF DEATH (Month, Day, Year): September 12, 89 | 3. TIME OF DEATH: 1527 M |
| 4. SOCIAL SECURITY NUMBER: 210 07 9725 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): August 7, 1914 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick | | 9c. COUNTY OF DEATH: Calvert |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MarylAND | 10b. COUNTY: Calvert | 10c. CITY, TOWN OR LOCATION: Lusby | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: SR 4 Box 275 Algonquin Trail | | 10f. ZIP CODE: 20657 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II, Korean | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retires Military | 16b. KIND OF BUSINESS/INDUSTRY: U S Armed Forces | |
| 17. FATHER'S NAME (First, Middle, Last): Amzi Watkins | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Priscilla May Struble | |
| 19a. INFORMANT'S NAME (Type/Print): Wayne Watkins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as # 10 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitian Crematory | 20c. LOCATION — City or Town, State: Alexandria Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ BRausch | | 22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home, 4405 Broomes Island Road, Port Republic, Maryland 20676 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Chronic arteriosclerotic | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Emad R. Al Banna M.D. | D12705 | ▶ 9/11/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
|---|---|---|
| Emad R. Al Banna.M.D. | Box 487 | Prince Frederick, MD. |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 13 1989 | Julia Davidson-Randall |

12. 1 Grahs

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Laura H. Collins | | | 2. DATE OF DEATH (Month, Day, Year): 08/23/89 | | 3. TIME OF DEATH: A M |
| 4. SOCIAL SECURITY NUMBER: 220-12-0564 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01/04/01 | | 8. BIRTHPLACE (State or Foreign Country): Delaware |
| 9a. FACILITY NAME (If not institution, give street and number): Rt. 2, Box 282 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Federalsburg | | 9c. COUNTY OF DEATH: Caroline |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Federalsburg | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 2, Box 282 | | 10f. ZIP CODE: 21632 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Albert Henry Waller | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Callaway Waller | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy M. Williams | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 283, Federalsburg, MD 21632 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | | 20c. LOCATION — City or Town, State: Federalsburg, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J Eshan | | | 22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Failure | 0 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Heart Disease | 5 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Generalized Atherosclerosis | 15 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Ceberal Vascular Accident, multiple, lates | 5 wks |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| H.R. Trapnell M.D. | D11021 | ▶ 8/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H.R. Trapnell, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 30 '89 | Lisa Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN ESTELLE SPARKLIN | | 2. DATE OF DEATH (Month, Day, Year): Aug. 17, 1989 | 3. TIME OF DEATH: 9:05P M |
| 4. SOCIAL SECURITY NUMBER: 214-34-6173 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5 28 1905 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): MD Route 313 & Adams Landing Rd | 9b. CITY, TOWN OR LOCATION OF DEATH: Denton | 9c. COUNTY OF DEATH: Caroline | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Hillsboro | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Church Street | 10f. ZIP CODE: 21641 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H.S. grad. College (1-4 or 5+): 3 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Store Operator | 16b. KIND OF BUSINESS/INDUSTRY: Pharmacy | |
| 17. FATHER'S NAME (First, Middle, Last): Wheatley William Holmes | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Estelle Powell | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Lou Segar | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 206P, Preston, MD 21655 | | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery | 20c. LOCATION — City or Town, State: Hillsboro, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randall Moore | 22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Denton, Maryland 21629 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Obstructive Nephropathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Cervical Cancer - Invasive
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Arterty Disease

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rob Lagnin | 29c. LICENSE NUMBER: D33294 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rob Lagnin MD PO Box 122 Goldsboro, Md. 21636 | | |
| 31. DATE FILED (Month, Day, Year): AUG 22 89 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Witt Becker, Linda Lee | | | 2. DATE OF DEATH (Month, Day, Year): 9 8 89 | 3. TIME OF DEATH: 0430 M |
| 4. SOCIAL SECURITY NUMBER: 219-26-1195 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/7/38 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Carroll Co. General Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Westminster | | 9c. COUNTY OF DEATH: Carroll |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Westminster | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 325 Kirkhoff Rd | | 10f. ZIP CODE: 21157 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stock Clerk | 16b. KIND OF BUSINESS/INDUSTRY: K-Mart | |
| 17. FATHER'S NAME (First, Middle, Last): Melvin Barr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Massey Harrington | |
| 19a. INFORMANT'S NAME (Type/Print): Howard J. Wittbecker | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 325 Kirkhoff Rd. Westminster, Md. 21157 | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial Gardens | 20c. LOCATION — City or Town, State: Finksburg, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Nancy K. Fletcher | | 22. NAME AND ADDRESS OF FACILITY: Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Md. 21157 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Atherosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | 25905 | ▶ 12 Sep 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard A. Jones, M.D. Carroll County General Hospital Westminster, Md. 21157

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 12 89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25830

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathleen M. Martin
2. DATE OF DEATH (Month, Day, Year): 9 - 3 - 89
3. TIME OF DEATH: 1950 P M
4. SOCIAL SECURITY NUMBER: 065-12-7576
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-27-23
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Carroll Co. General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Manchester
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3249 Chestnut St. Box 327
10f. ZIP CODE: 21102
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper
16b. KIND OF BUSINESS/INDUSTRY: Book Publishers
17. FATHER'S NAME (First, Middle, Last): Anthony Umla
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Schnepf
19a. INFORMANT'S NAME (Type/Print): Mr. Leonard Brown
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Central Avenue, Ridgefield Park, N.J. 07660
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Mem. Gardens
20c. LOCATION — City or Town, State: Finksburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerry S. Eline
22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Md. 21074

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia — 1 week

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: breast cancer - pulmonary lymphangitic disease; diabetes mellitus insulin dependent; benzodiazepine overdose

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D010179
29d. DATE SIGNED (Month, Day, Year): ▶ 4 September 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): SEP 5 '89
32. REGISTRAR'S SIGNATURE: [signature]

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

NORMA B. WAREHIME

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Norma B. Warehime | | | 2. DATE OF DEATH: Month 9 Day 5 Year 89 | 3. TIME OF DEATH: 4:45 P.M. |
| 4. SOCIAL SECURITY NUMBER: 215-74-2207 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6/24/1901 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): Westminster Nursing & Conv. Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Westminster | | 9c. COUNTY OF DEATH: Carroll |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD. | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Westminster | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2444 N. Old Bachman's Valley Rd. | | 10f. ZIP CODE: 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife | | 16b. KIND OF BUSINESS/INDUSTRY: n/a |
| 17. FATHER'S NAME (First, Middle, Last): Denton S. Warehime | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida M. Frock | | |
| 19a. INFORMANT'S NAME (Type/Print): Eleanor Shipley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Old Bachman's Valley Rd., Westminster Md. 21157 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Krider's Cemetery | | 20c. LOCATION — City or Town, State: Westminster, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert K Pritts Sr /wd Robert K. Pritts, Sr. | | 22. NAME AND ADDRESS OF FACILITY: 412 Washington Rd. Westminster, MD. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Pulmonary Failure | 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | 1 week |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fractured left hip

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard G Ekbergh MD

29c. LICENSE NUMBER: D01795

29d. DATE SIGNED (Month, Day, Year): 9/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): SEP 7 89

32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Benjamin S. Courtney | | | | 2. DATE OF DEATH (Month, Day, Year): August 17, 1989 | 3. TIME OF DEATH: 6:30A M |
| 4. SOCIAL SECURITY NUMBER: 216 12 6723 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-15-13 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Perry Point V.A.M.C. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point | | 9c. COUNTY OF DEATH: Cecil |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Aberdeen | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3252 Churchville Road | | 10f. ZIP CODE: 21001 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Military employee | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Army | |
| 17. FATHER'S NAME (First, Middle, Last): Albert Benjamin Courtney | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Belle Mitchell | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Iona Courtney | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3252 Churchville Road, Aberdeen, Maryland 21001 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens | 20c. LOCATION — City or Town, State: Aberdeen, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Tarring | | 22. NAME AND ADDRESS OF FACILITY: Tarring Funeral Home, P.A. 333 S. Parke St., Aberdeen, Md. 21001-3399 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aspiration Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Avelina Hernandez | 29c. LICENSE NUMBER: D27578 | 29d. DATE SIGNED (Month, Day, Year): 8-17-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AVELINA HERNANDEZ, M.D. | | |
| 31. DATE FILED (Month, Day, Year): AUG 21 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89-25833

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25833

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paul L. Davis | | | 2. DATE OF DEATH (Month, Day, Year): August 28, 1989 | 3. TIME OF DEATH: 1246 M |
| 4. SOCIAL SECURITY NUMBER: 221-10-0616 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 11, 1914 | 8. BIRTHPLACE (State or Foreign Country): New York |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County | 9b. CITY, TOWN OR LOCATION OF DEATH: Elkton | 9c. COUNTY OF DEATH: Cecil |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Cecil | 10c. CITY, TOWN OR LOCATION: Elkton | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 623 Delaware Avenue | | 10f. ZIP CODE: 21921 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indien, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Master Plumber | 16b. KIND OF BUSINESS/INDUSTRY: Plumbing and Heating | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Unknown | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown |
| 19a. INFORMANT'S NAME (Type/Print): Russell J. Sholl | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 62 Maloney Road Elkton, MD 21921 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gracelawn Memorial Park | 20c. LOCATION — City or Town, State: NewCastle, Delaware |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph E. Hicks | 22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, P.A. Bow and Stockton Streets Elkton, MD 21921 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Advanced lymphoma

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Yogish A. Patel | 29c. LICENSE NUMBER: C1000905 | 29d. DATE SIGNED (Month, Day, Year) ▶ 8 3 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Yogish Patel, M.D. 138 Cathedral Street Elkton, MD 21921 | | |
| 31. DATE FILED (Month, Day, Year): SEP 1 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Gilmer Frye (William G. Frye) | | | | 2. DATE OF DEATH (Month, Day, Year): September 2, 1989 | 3. TIME OF DEATH: 1215 M |
| 4. SOCIAL SECURITY NUMBER: 233-38-7772 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): April 5, 1927 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County | | 9b. CITY, TOWN OR LOCATION OF DEATH: Elkton | | 9c. COUNTY OF DEATH: Cecil | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Cecil | 10c. CITY, TOWN OR LOCATION: Elkton | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 100 Red Brick Road | | 10f. ZIP CODE: 21921 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY: Freight Transportation | |
| 17. FATHER'S NAME (First, Middle, Last): Edward Frye | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Vinia Adkins | | | |
| 19a. INFORMANT'S NAME (Type/Print): Marie Barlow | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 North Main Street Port Deposit, MD 21904 | | | |
| 20a. METHOD OF DISPOSITION: Sept. 5, 1989 — 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gilpin Manor Memorial Park | | 20c. LOCATION — City or Town, State: Elkton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ralph E. Hicks | | 22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, P.A. Bow and Stockton Streets Elkton, MD 21921 | | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CIRRHOSIS OF THE LIVER

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. APLASTIC ANEMIA + AGRANULOCYTOSIS

DUE TO (OR AS A CONSEQUENCE OF):

c. CHRONIC CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

d. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Rolando A. Najera | D07463 | 9-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rolando A. Najera, M.D. 105 East Main Street Elkton, MD 21921

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 5 '89 | Julia Davidson-Randall |

DHMH-1S Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jean Elizabeth Martin | | | 2. DATE OF DEATH (Month, Day, Year): August 29, 1989 | 3. TIME OF DEATH: 00:25 M |
| 4. SOCIAL SECURITY NUMBER: 216-20-4758 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 6 1928 | 8. BIRTHPLACE (State or Foreign Country): U.S.A. |
| 9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County | | 9b. CITY, TOWN OR LOCATION OF DEATH: Elkton | 9c. COUNTY OF DEATH: Cecil | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Cecil | 10c. CITY, TOWN OR LOCATION: Elkton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 17 Chesapeake Apartments | | 10f. ZIP CODE: 21921 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 8+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Worrol Watson Elmer, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Reba Creswell | |
| 19a. INFORMANT'S NAME (Type/Print): John D. Elmer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Chesapeake Apartments Elkton, MD 21921 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): R.A. Ferris & Co. | 20c. LOCATION — City or Town, State: West Cheter, Pa | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ | | 22. NAME AND ADDRESS OF FACILITY: Crouch Funeral Home 127 S. Main St. North East, MD 21901 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. COPD Emphysema

DUE TO (OR AS A CONSEQUENCE OF):

c. Brain Cerebral dysfunction from Anoxia (cardiac arrest)

DUE TO (OR AS A CONSEQUENCE OF):

d. Generalized Arteriolosclerosis vascular dis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jui Chih Hsu MD | 29c. LICENSE NUMBER: DO 4823 | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jui Chih Hsu MD 223 West main St. Elkton. Md 21921.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): AUG 30 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| FRANCES EMMA MCDONALD | | AUG. 28, 1989 | M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-22-3288 | 1 ☐ M 2 ☒ F X | 82 YRS. | | | MAR 1, 1907 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| UNION HOSPITAL | ELKTON | CECIL |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | CECIL | ELK MILLS | 1 ☐ YES 2 ☒ NO X |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| P.O. BOX 126 | 21920 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced XXX | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | HOUSEWIFE | HOME |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| UNKNOWN | NATTIE BULLOCK |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BETTY I. WHITE | P.O. BOX 217, RISING SUN, MARYLAND 21911 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | ROSEBANK CECMTERY | RISING SUN, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | R.T. FOARD FUNERAL HOME RISING SUN, MARYLAND |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. acute myocard infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. perforated bowel | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. multiple metastatic carcinoma. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO X | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D04823 | ▶ 8/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JUI Chih Hsu 223 West main St. Elkton MD 21921

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 30 '89 | Julia Davidson Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Harold Donithan Reed | | 2. DATE OF DEATH (Month, Day, Year): August 31 1989 | 3. TIME OF DEATH: Approx 1000 AM |
| 4. SOCIAL SECURITY NUMBER: 29-3-32-0374 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JUNE 25, 1934 |
| 8. BIRTHPLACE (State or Foreign Country): UNKNOWN | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 205 Sheffield Park | 9b. CITY, TOWN OR LOCATION OF DEATH: ELKTON MD | 9c. COUNTY OF DEATH: Cecil | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: CECIL | 10c. CITY, TOWN OR LOCATION: ELKTON | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 205 SHEFFIELD PK | 10f. ZIP CODE: 21921 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: UNKNOWN. | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN | |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY STREWBURY | | |
| 19a. INFORMANT'S NAME (Type/Print): MARY MORRIS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 SHEFFIELD PARK, ELKTON MD 21921 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SILVERBROOK CREMATORY | 20c. LOCATION — City or Town, State: WILMINGTON DEL. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: RT FOARD FUNERAL HOME 111 S. QUEEN ST. RISING SUN MD 21911 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Shotgun wound of the head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home | 28d. DESCRIBE HOW INJURY OCCURRED: Subject shot himself | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 905 Sheffield Park |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] Deputy Medical Examiner | D 17691 | August 31, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Juan C Gonzalez-Vitali MD, Union Hospital, Elkton MD 21921

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 18 1989 | [signature] |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 25838

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George Samuel Sickle | | | 2. DATE OF DEATH (Month, Day, Year): 9-11-89 | 3. TIME OF DEATH: 7:20AM M |
| 4. SOCIAL SECURITY NUMBER: 215-78-4071 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 29 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 9, 1960 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 2143 Keysville-Frederick County Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Keymar | 9c. COUNTY OF DEATH: Carroll County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Keymar | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2143 Keysville- Frederick County Rd. | | 10f. ZIP CODE: 21757 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Home Building | |
| 17. FATHER'S NAME (First, Middle, Last): Ray L. Sickle | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eunice Isabelle Ramsburg | |
| 19a. INFORMANT'S NAME (Type/Print): E. Isabelle Sickle | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2143 Keysville-Frederick Co. Rd. Taneytown, MD 21757 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Keysville Union Cemetery | 20c. LOCATION — City or Town, State: Keysville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John M. Skiles | 22. NAME AND ADDRESS OF FACILITY: Skiles Funeral Home 136 E. Baltimore St., Taneytown, MD 21787 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. DO not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Contact gunshot wound of the neck | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-10-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot self |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2143 Keysville-Frederick Co. Rd. Carroll County, Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita Korell | OCME | 9-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 12 89 | Julia Davidson Ramsburg |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELEANORA C. WIDEN | | | 2. DATE OF DEATH (Month, Day, Year): 08 27 89 | 3. TIME OF DEATH: 3:55 P M |
| 4. SOCIAL SECURITY NUMBER: 212-28-4859 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01-31-04 | 8. BIRTHPLACE (State or Foreign Country): SWEDEN |
| 9a. FACILITY NAME (If not institution, give street and number): CALVERT MANOR NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: 1881 TELEGRAPH RD RISING SUN, MD | | 9c. COUNTY OF DEATH: CECIL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: CECIL | 10c. CITY, TOWN OR LOCATION: ELKTON, MD | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3474 OLD ELK NECK RD | | 10f. ZIP CODE: 21921 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): GRADE 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOOD SERVICE WORKER | 16b. KIND OF BUSINESS/INDUSTRY: FOOD SERVICE | |
| 17. FATHER'S NAME (First, Middle, Last): BROR VENNBURG | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA DEVERDIEV | |
| 19a. INFORMANT'S NAME (Type/Print): MARGARET HARRIS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 NOTTINGHAM RD. ELKTON MD 21921 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 31, 1989 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gilpin Manor Memorial Park | 20c. LOCATION — City or Town, State: Elkton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph E. Hicks | 22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, P.A. Bow & Stockton Streets Elkton, MD 21921 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute/Chr Congestive Heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. hypothyroidism
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jayanti Lal K Patel MD | 29c. LICENSE NUMBER: D22307 | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAYANTILAL K PATEL MD - 123 Singerly Ave, Elkton MD 21921 | | |
| 31. DATE FILED (Month, Day, Year): AUG 31 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

89 25840

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Della Mary Bowie | | | 2. DATE OF DEATH (Month, Day, Year): September 8, 1989 | 3. TIME OF DEATH: 3:40 PM |
| 4. SOCIAL SECURITY NUMBER: 218-58-1636 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 09/22/02 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: La Plata | | 9c. COUNTY OF DEATH: Charles |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Charles | 10c. CITY, TOWN OR LOCATION: Nanjemoy | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO XX |
| 10e. STREET AND NUMBER: Bowie Road , P.O. Box 13 | | 10f. ZIP CODE: 20662 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XX | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XX. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: At Home | |
| 17. FATHER'S NAME (First, Middle, Last): Rodrick G. Milstead | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jane Rison | |
| 19a. INFORMANT'S NAME (Type/Print): Anna Betty Makowelski -Daughter | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 13, Nanjemoy, Md. 20662 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chicamuxen Methodist Cem. | 20c. LOCATION — City or Town, State: Chicamuxen, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dayton C Echols Jr | 22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. P.O. Box 567 , La Plata, Md. 20646 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Renal failure | 12 days |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Gastrointestinal bleeding | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. duodenal ulcer | 5 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | d. Hypertension | 25 yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart failure, Urinary Tract infection, gallstones, chronic obstructive lung disease, anemia, arteriosclerosis, sepsis, dehydration

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURRED: N/A | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul E. Pritchett Jr MD | 29c. LICENSE NUMBER: D08370 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul E. Pritchett, M.D. — 118 La Grange Ave., P.O. Box 1317, La Plata, Maryland 20646

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25841

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sylvester Cobey Jr. | | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 9 / 89 | 3. TIME OF DEATH: 1220h M |
| 4. SOCIAL SECURITY NUMBER: 212-30-8217 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/10/33 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA | | 9c. COUNTY OF DEATH: CHARLES |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: CHARLES | 10c. CITY, TOWN OR LOCATION: NANJEMOY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: ROUTE # 6 BOX 94E | | 10f. ZIP CODE: 20662 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE; College (1-4 or 5 +): NONE | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): GROUNDSKEEPER | 16b. KIND OF BUSINESS/INDUSTRY: GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last): SYLVESTER COBEY, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ETHEL GAINES | |
| 19a. INFORMANT'S NAME (Type/Print): ROSIE MARY COBEY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ROUTE #6 BOX 94E NANJEMOY, MARYLAND 20662 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK GROVE BAPTIST CHURCH CEM. | 20c. LOCATION — City or Town, State: GRAYTON, MARYLAND |
| 21. SIGNATURE OF FUHERAL SERVICE LICENSEE: ▶ Lydia C. Thornton Johnson | | 22. NAME AND ADDRESS OF FACILITY: THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. COPD | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H M Hoff Chief Medical Examiner | | 29c. LICENSE NUMBER: D27348 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H M Hoff 3456 Tamarack Ct. Waldorf MD 20601 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 12 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

89 2581

89 25842

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CATHERINE CECELIA FREEZE | | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 7 1989 | 3. TIME OF DEATH: 10:56 P M |
| 4. SOCIAL SECURITY NUMBER: 577-32-0240 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/08/03 | 8. BIRTHPLACE (State or Foreign Country): Washington, D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA | | 9c. COUNTY OF DEATH: CHARLES | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: St. Mary's | 10c. CITY, TOWN OR LOCATION: Mecanicsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 50 Beach Drive | | 10f. ZIP CODE: 20659 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker | 16b. KIND OF BUSINESS/INDUSTRY: At Home | |
| 17. FATHER'S NAME (First, Middle, Last): John Joseph Hughes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bridget Cecelia Boucher | |
| 19a. INFORMANT'S NAME (Type/Print): Carol Tyler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50 Beach Drive, Golden Beach, Mechanicsville | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery | 20c. LOCATION — City or Town, State: Clinton, Md. Md. 20659 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clayton C Echols Jr | | 22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. P.O. Box 567, La Plata, Md. 20646 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Edema | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ischemic Cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D 25992 | ▶ 9 8 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KHADAR BAIG, M.D, P O BOX 190 18 N, 301 Hgwy LA PLATA, Md. 20646

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25843

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained by the funeral director for use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Albert WILLIAM ALBERT HIGGS Higgs | | | 2. DATE OF DEATH: MONTH 09 DAY 02 YEAR 1989 | 3. TIME OF DEATH: 11:30 P M |
| 4. SOCIAL SECURITY NUMBER: 578 03 4635 | 5. SEX: 1 ☐ M 2 ☐ F X | 6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-25-1911 | 8. BIRTHPLACE (State or Foreign Country): WASHINGTON D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: LaPlata | | 9c. COUNTY OF DEATH: Charles |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: CHARLES | 10c. CITY, TOWN OR LOCATION: WALDORF | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 114 ELL LANE | | 10f. ZIP CODE: 20601 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4 or 5+): ------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TYPEWRITER MECH. | 16b. KIND OF BUSINESS/INDUSTRY: SELF | |
| 17. FATHER'S NAME (First, Middle, Last): James Higgs | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Taylor | |
| 19a. INFORMANT'S NAME (Type/Print): James R. Higgs | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 230 Autumn Chase Drive Annapolis Md. 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peter'S Cemetery | 20c. LOCATION — City or Town, State: Waldorf, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home, Inc. P.O. Box 156 Waldorf, Md. 20604 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. urinary tract infection | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic heart disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Banerjee M.D. | 29c. LICENSE NUMBER: D09247. | 29d. DATE SIGNED (Month, Day, Year): ▶ 9.3.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chinmoy Banerjee M.D. Charles Prof. Bldg. #200 Box 22 Waldorf, Md. 20601

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25844

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Theodore De LOZIER | | | 2. DATE OF DEATH (Month / Day / Year): 09 09 1989 | 3. TIME OF DEATH: 04:45A M |
| 4. SOCIAL SECURITY NUMBER: 217-42-8532 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8-29-1900 | 8. BIRTHPLACE (State or Foreign Country): RISON, MD |
| 9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: LaPlata | | 9c. COUNTY OF DEATH: Charles |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: CHARLES | 10c. CITY, TOWN OR LOCATION: MARBURY | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: P.O. BOX 146 | | 10f. ZIP CODE: 20658 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN | | 16b. KIND OF BUSINESS/INDUSTRY: NAVAL ORD. STATION, GOVT. | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN THOMAS DE LOZIER | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CLARA BARTON REES | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. MILDRED DE LOZIER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 156, MARBURY, MD 20658 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARK HILL CEMETERY | | 20c. LOCATION — City or Town, State: MARBURY, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mildred Blakenship | 22. NAME AND ADDRESS OF FACILITY: THE HUNTT FUNERAL HOME, INC P.O. BOX 156,WALDORF,MD 20604-0156 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrovascular Accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Septicemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Post Cholecystectomy - Gangrenous Gallbladder | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Atherosclerosis
2. Genitourinary Tract Infection
3. Metabolic Encephalopathy

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Henry L Burke MD | 29c. LICENSE NUMBER: D01009 | 29d. DATE SIGNED (Month, Day, Year): ▶ ~~9-10~~ 9-9-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry L. Burke M.D. 115-A LaGrange Ave, POB591 LaPlata Md. 20646 | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall | |

DHMH-16 Rev 1/89

89 25845

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Myrtle E. Miller
2. DATE OF DEATH (Month, Day, Year): 09 03 1989
3. TIME OF DEATH: 04:00A M
4. SOCIAL SECURITY NUMBER: 577-09-1894
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-12-1909
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 16 Somerset Street
9b. CITY, TOWN OR LOCATION OF DEATH: La Plata
9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Charles
10c. CITY, TOWN OR LOCATION: LaPlata
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 16 Somerset Street
10f. ZIP CODE: 20646
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Sebastian Welch
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Higgs
19a. INFORMANT'S NAME (Type/Print): Donald Garner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 Somerset St., La Plata, Md. 20646
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery
20c. LOCATION — City or Town, State: Suitland, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jason F. Huntt
22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home, P. O. Box 156, Waldorf, Md. 20604-0156

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma Bladder — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Carcinoma Bladder. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NONE.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mohammed Hazig
29c. LICENSE NUMBER: D 13307
29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mohammed Hazig M.D. Charles Prof. Center #405 Waldorf, Md. 20601
31. DATE FILED (Month, Day, Year): SEP 06 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Items:23,27 per ME G-656
10-27-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25846

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jason Patrick SCHULZ
2. DATE OF DEATH (Month, Day, Year): 9-5-89
3. TIME OF DEATH: 11:00AM M
4. SOCIAL SECURITY NUMBER: 217-23-6358
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 6, DAYS 25 — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): FEB. 10, 1989
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: La Plata
9c. COUNTY OF DEATH: Charles County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: CHARLES
10c. CITY, TOWN OR LOCATION: 48 MATTINGLY AVENUE INDIAN HEAD
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 48 MATTINGLY AVENUE
10f. ZIP CODE: 20640
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): INFANT — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHILD
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): CURTIS LYNN SCHULZ
18. MOTHER'S NAME (First, Middle, Maiden Surname): CARYL STACIE WILLETT
19a. INFORMANT'S NAME (Type/Print): CURTIS L. SCHULZ
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 48 MATTINGLY AVE. INDIAN HEAD, MD. 20640
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. REST CEMETERY
20c. LOCATION — City or Town, State: LA PLATA, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael O. Legnard
22. NAME AND ADDRESS OF FACILITY: AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND 20646

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 9-6-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vc
31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25847

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WALTER EDWARD SIMMONS | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 3 1989 | 3. TIME OF DEATH: 7:26 PM |
| 4. SOCIAL SECURITY NUMBER: 223-07-2283 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 3, 1898 |
| 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA MD. | 9c. COUNTY OF DEATH: CHARLES | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: CHARLES | 10c. CITY, TOWN OR LOCATION: BRYANS ROAD | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10a. STREET AND NUMBER: Route 2 Box 197A | 10f. ZIP CODE: 20616 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): FOURTH; College (1-4 or 5+): NONE | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC TRT | 16b. KIND OF BUSINESS/INDUSTRY: CITY GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN THOMAS SIMMONS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HAVANNAH BARROW | | |
| 19a. INFORMANT'S NAME (Type/Print): HAVANNAH S. MORTON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2 Box 197A Bryans Road, Maryland 20616 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CALVARY CEMETERY | 20c. LOCATION — City or Town, State: NORFOLK, VIRGINIA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON | 22. NAME AND ADDRESS OF FACILITY: THORNTON FUNERAL HOME POMONKEY, MARYLAND | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R Pace MD | 16117 | ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT T. PACE M.D. P.O. BOX 249 WALDORF MD. 20640

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 06 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 2584

89 25848

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathryn Anne Strickland
2. DATE OF DEATH (Month, Day, Year): August 28,1989
3. TIME OF DEATH: 12:18 a M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR MONTHS 2 DAYS 14; IF UNDER 24 HRS. HOURS MIN.:
7. DATE OF BIRTH (Month, Day, Year): June 14,1989
8. BIRTHPLACE (State or Foreign Country): Washington,D.C.
9a. FACILITY NAME (If not institution, give street and number): Hwy 232, Box 259
9b. CITY, TOWN OR LOCATION OF DEATH: Waldorf
9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Charles
10c. CITY, TOWN OR LOCATION: Waldorf
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Hwy 232, Box 259
10f. ZIP CODE: 20601
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): n/a
16b. KIND OF BUSINESS/INDUSTRY: n/a
17. FATHER'S NAME (First, Middle, Last): David B. Strickland
18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa A. Boteler
19a. INFORMANT'S NAME (Type/Print): Theresa A. Strickland (mother)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 a-f
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery
20c. LOCATION — City or Town, State: Clinton, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeranne L Boteler
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, MD 20735

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congenital Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

c. Truancy 18

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Miller Pedodontist
29c. LICENSE NUMBER: D24265
29d. DATE SIGNED (Month, Day, Year): ▶ 28AUG89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robert Miller, Pembrooke Sq., Hwy 301S., suite 110, Waldorf, MD 20603-4806

31. DATE FILED (Month, Day, Year): SEP 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25849

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elton W. Thompson | 2. DATE OF DEATH (Month / Day / Year): 9 / 5 / 89 | 3. TIME OF DEATH: 1:27 A M | |
| 4. SOCIAL SECURITY NUMBER: 218-14-3736 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 28, 1924 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA | 9c. COUNTY OF DEATH: CHARLES | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: CHARLES | 10c. CITY, TOWN OR LOCATION: MARBURY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: #12 RICHARD LAWRENCE DRIVE | 10f. ZIP CODE: 20658 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1944-1964 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4 or 5+): NONE | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): POSTAL EMPLOYEE | 16b. KIND OF BUSINESS/INDUSTRY: GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last): WALTER THOMPSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ETHEL BROWN | | |
| 19a. INFORMANT'S NAME (Type/Print): LOUISE THOMPSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): #12 RICHARD LAWRENCE DRIVE, MARBURY, MARYLAND 20658 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY | 20c. LOCATION — City or Town, State: CHELTENHAM, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON | 22. NAME AND ADDRESS OF FACILITY: THORNTON'S FUNERAL HOME POMONKEY, MARYLAND 20640 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ASCVD | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | renal failure | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H.M. Hafner DMD & Dep Med Examiner | 29c. LICENSE NUMBER: D27348 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. M. Hafner MD 3756 Tamarack Ct, Waldorf Md 20601 | | |
| 31. DATE FILED (Month, Day, Year): SEP 06 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25850
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN JOSEPH DWYER, SR.
2. DATE OF DEATH (Month, Day, Year): 09 09 89
3. TIME OF DEATH: 1:30 M
4. SOCIAL SECURITY NUMBER: 719-01-2962
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 27, 1911
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Mallard Bay Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Cambridge
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 210 Meteor Avenue
10f. ZIP CODE: 21613
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 12-26-28 - 12-10-30
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman
16b. KIND OF BUSINESS/INDUSTRY: B&O Railroad
17. FATHER'S NAME (First, Middle, Last): unavailable
18. MOTHER'S NAME (First, Middle, Maiden Surname): unavailable
19a. INFORMANT'S NAME (Type/Print): Mrs. Lorraine Dwyer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5613 Queenschapel Road, Hyattsville, Maryland 20782
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul A. Bohanan
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Balt. Ave., Hyattsville, Md. 20781

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrythmia | Minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Arteriosclerotic Cardiovascular Disease | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund J. MacLaughlin MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edmund J. MacLaughlin 10 Aurora St. Cambridge, Md 21613

31. DATE FILED (Month, Day, Year): SEP 11 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 4:40

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Evelyn E. Hall (Evelyn E Hall Hall) | | | 2. DATE OF DEATH (Month, Day, Year): 09-04-89 | 3. TIME OF DEATH: 4:40 A.M |
| 4. SOCIAL SECURITY NUMBER: 214-07-8287 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Mar 14, 1916 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge | 9c. COUNTY OF DEATH: Dorchester | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Dorchester | 10c. CITY, TOWN OR LOCATION: Cambridge | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 1101 Race Street | | 10f. ZIP CODE: 21613 | 10g. CITIZEN OF WHAT COUNTRY?: US | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 15b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Charles G. Kahl | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Curtin | | |
| 19a. INFORMANT'S NAME (Type/Print): Harold E. Hall | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1101 Race St. Cambridge, Md. 21613 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Lawn Cemetery Thomas Funeral Home | 20c. LOCATION — City or Town, State: Cambridge, MD. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John W. Thomas | | 22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Transitioual cell Carcuowo | |
| DUE TO (OR AS A CONSEQUENCE OF): | of Kidney and Bladder (Metastatic Transitioual cell Carcuowa of Kidney & Bladder.) | 9 mos. / 9 mos. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| attending physician | D23207 | ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raul Diaz, M.D. 200 Maryland Ave., Cambridge, MD 21613

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 09/04/89 | Ronald W Robbins (Security Guard) |

SEP - 6 '89

in Davidson-Randall

DHMH-15 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Morley A. Jull (Morley Jull) | | | 2. DATE OF DEATH Month 8 Day 22 Year 89 | 3. TIME OF DEATH 12:45 PM (12:45 P) M |
| 4. SOCIAL SECURITY NUMBER 214-30-1074 (XXXX) | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4/19/1931 |
| 8. BIRTHPLACE (State or Foreign Country) Wash, D.C. | | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH Cambridge | 9c. COUNTY OF DEATH Dorchester |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Maryland | 10b. COUNTY Dorchester | 10c. CITY, TOWN OR LOCATION Cambridge | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER 1667 Town Point Road | 10f. ZIP CODE 21613 | 10g. CITIZEN OF WHAT COUNTRY? US | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Educator | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) Morley Allen Jull, Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Louise Monkley |
| 19a. INFORMANT'S NAME (Type/Print) Judy M. Jull | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1667 Town Point Road Cambridge, Md. 21613 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Old Trinity Churchyard | 20c. LOCATION — City or Town, State Church Creek, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Thomas J. Thomas | 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust Street Cambridge, Md. 21613 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Liver Failure | Months |
| | DUE TO (OR AS A CONSEQUENCE OF): Alcohol Addiction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | Years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER H.C. Ayliffe MD | Howard Ayliffe, M.D. | 29c. LICENSE NUMBER D31018. | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/22/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H.C. Ayliffe, M.D. | Howard Ayliffe, M.D. 408 Byrn Street | | Cambridge, M.D. 21613 |
| 31. DATE FILED (Month, Day, Year) AUG 24 '89 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charlotte Ann Phillips
2. DATE OF DEATH (Month, Day, Year): Aug 29, 1989
3. TIME OF DEATH: 4:30 PM M
4. SOCIAL SECURITY NUMBER: 213-24-4387
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/28/1928
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 202 Bay Country Village
9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Cambridge
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 202 Bay Country Village
10f. ZIP CODE: 21613
10g. CITIZEN OF WHAT COUNTRY? US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+): 4
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher/Model
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Hobart Phillips
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Hearn
19a. INFORMANT'S NAME (Type/Print): Ruth Hearn Phillips
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 708 Locust St. Cambridge, Md. 21613
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Memorial Park
20c. LOCATION — City or Town, State: Cambridge, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John W Thomas
22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cerebral metastases | weeks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Squamous cell CA lung RUL | months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Squamous cell CA larynx

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRISE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lewis M. Burdette MD
29c. LICENSE NUMBER: D00850
29d. DATE SIGNED (Month, Day, Year): ▶ 30 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lewis M. Burdette 4 Aurora St Cambridge Md
31. DATE FILED (Month, Day, Year): SEP 1 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

DHMH-16 Rev 1/89

89 25854

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Beulah Simmons Rasin | | 2. DATE OF DEATH (Month, Day, Year): Aug 29, 1989 | 3. TIME OF DEATH: 3:30 AM |
| 4. SOCIAL SECURITY NUMBER: 212-10-0261 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4/12/1905 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Tender Love 604 Locust Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge | 9c. COUNTY OF DEATH: Dorchester | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Dorchester | 10c. CITY, TOWN OR LOCATION: Cambridge | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1100 Holland Avenue | 10f. ZIP CODE: 21613 | 10g. CITIZEN OF WHAT COUNTRY?: US | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ND IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 6 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Telephone Operator | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph W. Simmons | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Wroten | | |
| 19a. INFORMANT'S NAME (Type/Print): Jill Corkran | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 338 Hurlock, Md. 21643 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chester Cemetery | 20c. LOCATION — City or Town, State: Chestertown, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY ARTERY DISEASE | 4 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ATHEROSCLEROSIS | 4 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| — | — M | 1 ☐ YES 2 ☐ ND | — |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Michael A. Moskewicz MD | D 16609 | ▶ 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL A. MOSKEWICZ MD 503 BYRN ST. CAMBRIDGE MD. 21613

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP - 1 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25855

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elwood Sampson (Elwood Sampson) | | | 2. DATE OF DEATH: MONTH 8 DAY 23 YEAR 89 | 3. TIME OF DEATH: 9:12 PM |
| 4. SOCIAL SECURITY NUMBER: 220-28-2208 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/26/31 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Dorchester Gen. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge | 9c. COUNTY OF DEATH: Dorchester | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Dorchester | 10c. CITY, TOWN OR LOCATION: Cambridge | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 300 Byrn St. | | 10f. ZIP CODE: 21613 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Benjamin F. Sampson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Mae Jackson | |
| 19a. INFORMANT'S NAME (Type/Print): Orlando Cornish | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): U.S. Army Germany | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Veteran Cem | 20c. LOCATION — City or Town, State: Hurlock, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Janelle C. Hen | 22. NAME AND ADDRESS OF FACILITY: Stewart F. H. Camb. Md. 21613 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | Acute Myocardial Infarction / Coronary Artery Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary Artery Disease | years |
| DUE TO (OR AS A CONSEQUENCE OF): | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcoholism — Chronic Alcoholism
Chronic Obstructive Pulmonary Disease — Chronic Obstructive Pulmonary Disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund J. MacLaughlin | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 8-23-89 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edmund J. MacLaughlin — 10 Aurora St., Cambridge, Md. 21613 (Edmund J. MacLaughlin — 10 Aurora St. Cambridge Md 21613) | | |
| 31. DATE FILED (Month, Day, Year): SEP - 1 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

88 52822

89 25856

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sherwood Tyler / Sherwood Augustus Tyler | | | 2. DATE OF DEATH: MONTH 9 DAY 5 YEAR 89 | 3. TIME OF DEATH: 8.15 PM |
| 4. SOCIAL SECURITY NUMBER: 213-14-7355 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/11/16 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Dorchester Gen. Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge | 9c. COUNTY OF DEATH: Dorchester | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Dorchester | 10c. CITY, TOWN OR LOCATION: Cambridge | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 520 Glenburn Avenue | 10f. ZIP CODE: 21613 | 10g. CITIZEN OF WHAT COUNTRY?: US | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman | 16b. KIND OF BUSINESS/INDUSTRY: Seafood | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Bounds Tyler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Irene Gore | | |
| 19a. INFORMANT'S NAME (Type/Print): James F. Tyler | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 214 Hurlock, Md. 21643 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Memorial Park | 20c. LOCATION — City or Town, State: Cambridge, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, MD. 21613 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hyperglycemia | |
| DUE TO (OR AS A CONSEQUENCE OF): | Hyperglycemia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Uncontrolled D. Mellitus | |
| | Uncontrolled D. Mellitus | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD, Old CVA, Organic B. Syn. / ASCVD, Old CVA, Organic B. Syn.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9-5-89 / 9-5-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): SEP - 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 52829

89 25857

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAYMOND N. TOWERS | | | | 2. DATE OF DEATH (Month, Day, Year): 08/29/89 | 3. TIME OF DEATH: 9:30 AM |
| 4. SOCIAL SECURITY NUMBER: 217-36-1063 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07/31/07 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 4953 Skeet Club Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Hurlock | | 9c. COUNTY OF DEATH: Dorchester |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Dorchester | 10c. CITY, TOWN OR LOCATION: Hurlock | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4953 Skeet Club Road | | 10f. ZIP CODE: 21643 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Agriculture | |
| 17. FATHER'S NAME (First, Middle, Last): Purnell Waitman Towers | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Virginia Todd | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Tina T. Jacobs | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4953 Skeet Club Road, Hurlock, MD 21643 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Junior Order Cem. | 20c. LOCATION — City or Town, State: Preston, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael F. Eskow | | 22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous myocardial infarction; Senile dementia; Alzimers disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James F. McCarter, MD | 29c. LICENSE NUMBER: D 07052 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James F. McCarter, M.D., 400 Aurora Street, Cambridge, Maryland 21613 | | |
| 31. DATE FILED (Month, Day, Year): SEP - 5 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

89 25857

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25858

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRY LEE DAY | | | 2. DATE OF DEATH: MONTH 9 DAY 8 YEAR 89 | 3. TIME OF DEATH: 2:10 AM M |
| 4. SOCIAL SECURITY NUMBER: 719-10-4057 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 2, 1911 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital, Inc. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frederick | 9c. COUNTY OF DEATH: Frederick | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Mt. Rainier | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 4100 32nd Street | | 10f. ZIP CODE: 20712 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter | 16b. KIND OF BUSINESS/INDUSTRY: Decorating | | |
| 17. FATHER'S NAME (First, Middle, Last): John Day | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Woods | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Harry Day | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4100 32nd Street, Mt. Rainier, Maryland 20712 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert G Bohanan | 22. NAME AND ADDRESS OF FACILITY: FRANCIS GASCH'S SONS FUNERAL HOME 4739 Balt. Ave., Hyattsville, Md. 20781 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Neoplasm | 2 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cirrhosis

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 X NO | HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| L Kinland MD | D 22037 | ▶ 9-9-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L KINLAND 610 NINTH AVE BRUNSWICK, MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

6

88 52028

89 25859

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LAURA PEARL PENNINGTON | | | 2. DATE OF DEATH (Month, Day, Year): Sep. 02, 1989 | 3. TIME OF DEATH: 9:25PM M |
| 4. SOCIAL SECURITY NUMBER: 213-74-5159 | 5. SEX: 1 ☐ M 2 ☐ FEMALE | 6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02/25/96 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK | | 9c. COUNTY OF DEATH: FREDERICK |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: FREDERICK | 10c. CITY, TOWN OR LOCATION: FREDERICK | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: NO |
| 10a. STREET AND NUMBER: 9502 HANSONVILLE RD. | | 10f. ZIP CODE: 21701 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced: W | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: NO | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM DAVID GREER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA CLAPP | | |
| 19a. INFORMANT'S NAME (Type/Print): TERESA CRAMER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13646 UNIONVILLE RD. UNION BRIDGE MD 21791 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINGANORE CEMETERY | 20c. LOCATION — City or Town, State: UNIONVILLE, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catharine O. Hartzler | 22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS LIBERTYTOWN, MD | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure | 2d |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): CHF | 5 yrs |
| | c. DUE TO (OR AS A CONSEQUENCE OF): ASCVD | 20 yrs |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John Lehigh MD | D20330 | 9/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Lehigh, 104 N Main St., Union Bridge, MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 7 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

Items:23,27 per ME G-656
10-18-89 cm

89 25860

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Calvin / Lester / L. / Stone | | | 2. DATE OF DEATH (Month, Day, Year): 8-29-89 | 3. TIME OF DEATH: 12:30PM M |
| 4. SOCIAL SECURITY NUMBER: 215-42-3556 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 4, 1944 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 316 W. College Terrace | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frederick | 9c. COUNTY OF DEATH: Frederick County | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Frederick | 10c. CITY, TOWN OR LOCATION: Frederick | 10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 316 West College Terrace | | 10f. ZIP CODE: 21701 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Lawn Service | | |
| 17. FATHER'S NAME (First, Middle, Last): Earl K. Stone | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn V/ Allison | | |
| 19a. INFORMANT'S NAME (Type/Print): Claude W. Stone | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 921 East C Street, Brunswick, Md. 21716 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory | 20c. LOCATION — City or Town, State: Smithsburg, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Graf M00255 | | 22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin, M.D. | OCME | ▶ 8-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 15 1989 | Julia Davidson-Randall |

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2586O

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25861
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Virginia | Esta | BITTINGER | August 21, 1989 | 830 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 234-70-1383 | 1 ☐ M 2 ☒ F | 84 YRS. | | | Apr. 21, 1905 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Garrett County Memorial Hospital | Oakland | Garrett |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Garrett | Oakland | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Rt. 3, Box 107 | 21550 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 7th | | Housewife | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William ----- Cosner | Ellen ----- Anderson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Harold W. Bittinger | Rt. 3, Oakland, MD 21550 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Fairview Cemetery | Oakland, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Bradley A. Stewart | Stewart Funeral Home<br>32 S. Second St., Oakland, MD 21550 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | 3 dep |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Liver Failure | 2-3 wks |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Hepatic Inflamation — Etio? (Bx pending) | 20 yrs |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D15333 | ▶ 8/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
H. L. Johnson 311 North 4th St Oakland MD 21550

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 25 '89 | [signature] |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| IRENE | CATHERINE | BIRD | Sept. 6, 1989 | 3:12 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 209-22-6373 | 1 ☐ M 2 ☒ F | 61 YRS. | | | 7/27/1928 | PA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| New Gravel Hill Rd, Box 14 | Friendsville, | Garrett |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| PA | Fayette | Markleysburg, | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| R.D. 1, Box 24 | 15459 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| 9 | | Homemaker | Own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Michael Novobilsky | Anna Karnus |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia A. Bowser | P.O. Box 14; Friendsville, MD 21531 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Thomas Cemeyt Cemetery | Markleysburg, PA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Donald Lyn Newman | NEWMAN FUNERAL HOMES, P.A. 155 Main St. Grantsville, MD 21536 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic adenocarcinoma of lung | 4 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margaret A Kaiser MD | D26650 | ▶ 9/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margaret A. Kaiser, M.D. ; Oakland, MD 21550

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Gloria Faidley Rendall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lawrence Bartholome DUNITHAN | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 6, 1989 | 3. TIME OF DEATH: 0655 A M |
| 4. SOCIAL SECURITY NUMBER: 233-09-2684 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 98 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Mar. 25, 1891 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Garrett County MemorialHospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | | 9c. COUNTY OF DEATH: Garrett |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: WV | 10b. COUNTY: Grant | 10c. CITY, TOWN OR LOCATION: Bayard | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: P.O. Box 87 | | 10f. ZIP CODE: 26707 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW I | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Coal Miner | 16b. KIND OF BUSINESS/INDUSTRY: Coal Mining | |
| 17. FATHER'S NAME (First, Middle, Last): Charles A. Dunithan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Shell | |
| 19a. INFORMANT'S NAME (Type/Print): Edward Dunithan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 116, Bayard, West Virginia 26707 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bayard Cemetery | 20c. LOCATION — City or Town, State: Bayard, West Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumonia | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Aspiration | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D33464 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P.O. Box 8 Eglon WV 26716 | | |
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sadie Katherine FIKE | | 2. DATE OF DEATH (Month, Day, Year): August 28, 1989 | 3. TIME OF DEATH: 100 A M |
| 4. SOCIAL SECURITY NUMBER: 220-26-7676 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 19, 1933 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Garrett County MemorialHospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | 9c. COUNTY OF DEATH: Garrett | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Oakland | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 5, Box 53 | 10f. ZIP CODE: 21550 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): Ira H. Paugh | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Mae Paugh | | |
| 19a. INFORMANT'S NAME (Type/Print): William W. Fike, Sr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 5, Box 53, Oakland, Maryland 21550 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery | 20c. LOCATION — City or Town, State: Swanton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 S. Second St., oakland, MD 21550 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cancer of Breast | ~~2 yrs~~ 6 mo |
| DUE TO (OR AS A CONSEQUENCE OF): | Mets to lungs + Bone | since ox |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD - Chronic Bronchitis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: T. Johnson MD | 29c. LICENSE NUMBER: D15333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550 | | |
| 31. DATE FILED (Month, Day, Year): AUG 30 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25865

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bertha Ellen Harvey | | | 2. DATE OF DEATH (Month, Day, Year): 8-22-89 | 3. TIME OF DEATH: 12:30PM M |
| 4. SOCIAL SECURITY NUMBER: 218-22-9573 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept 27, 1918 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | 9c. COUNTY OF DEATH: Garrett County | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Oakland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 502 E. Alder Street | | 10f. ZIP CODE: 21550 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): James L. Walters | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Katherine Bittinger | | |
| 19a. INFORMANT'S NAME (Type/Print): William L. Harvey | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 298 Oakland, Maryland 21550 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): White Church Cemetery | 20c. LOCATION — City or Town, State: Deer Park, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert H. Durst M00167 | 22. NAME AND ADDRESS OF FACILITY: P.O. Box 243 Durst Funeral Home - Oakland, Maryland | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Thoracoabdominal injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? XX ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8-22-89 | 28b. TIME OF INJURY: 11:15AM | 28c. INJURY AT WORK? 1 ☐ YES 2 XX NO | 28d. DESCRIBE HOW INJURY OCCURED: Passenger in auto/auto impact |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2 miles N. of MD Rt. 42/junction Rt 219 Garrett County, Maryland |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes, M.D. | OCME | ▶ 8-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 24 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25866

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25866

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Miriam Walburg HART | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 6, 1989 | 3. TIME OF DEATH: 6:00 P M |
| 4. SOCIAL SECURITY NUMBER: 097-38-6982 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1903 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): GarrettCounty Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | | 9c. COUNTY OF DEATH: Garrett |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Deer Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 4, Box 130-A | | 10f. ZIP CODE: 21550 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): James ----- Chamberlain | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine ----- O'Neil | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Roberta G. Anderson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 4, Box 130-A, Deer Park, Maryland 21550 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery | 20c. LOCATION — City or Town, State: Brooklyn, New York |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Buddy A. Stewart | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 S. Second St., Oakland, mD 21550 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest — Sudden

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. severe chronic obstructive pulmonary disease — Years

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

carcal decubitus
malnutrition
senile osteoporosis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Donald R Richter MD | 29c. LICENSE NUMBER: D30035 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Donald R. Richter, MD 311 N. Fourth St., Oakland, Maryland 21550

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

15

89 25866

89 25867

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ward / Ishmel / Livengood | | | 2. DATE OF DEATH MONTH DAY YEAR: 9-5-89 | 3. TIME OF DEATH: 5:20PM M |
| 4. SOCIAL SECURITY NUMBER: 233-44-5004 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 16, 1910 |
| 8. BIRTHPLACE (State or Foreign Country): West Virginia | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 301 S. Second Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | | 9c. COUNTY OF DEATH: Garrett County |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Oakland | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 301 South Second Street, Apt. A | | 10f. ZIP CODE: 21550 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Leslie ----- Livengood | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth ----- Friend | | |
| 19a. INFORMANT'S NAME (Type/Print): Josephine H. Livengood | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 806 Philadelphia Ave., Mt. Lake Park, MD 21550 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrett Co. Memorial Gardens | 20c. LOCATION — City or Town, State: Oakland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brenda K. Stewart | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 [ ] NO PARTIAL | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 XXX Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: XXX 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-6-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 | | VC |
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25868

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Elsie | Spencer | McGUIRE | August 26, 1989 | 11:35a M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 165-50- 7507 | 1 ☐ M 2 ☒ F | 89 YRS. | | | Aug. 10, 1900 | Nebraska |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Dennett Road Manor Nursing Home | Oakland | Garrett |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Garrett | Mt. Lake Park | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 124 Oak Hall Drive | 21550 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| | 2+ | Housewife | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William Issac SPENCER | Iowa Belle HENRY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret Mahood | 215 H. Street Mt. Lake Park, MD 21550 |

| 20a. METNOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Riverview Cemetery | Aurora Indiana |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Franklin H. Custer | Stewart Funeral Home<br>32 S. Second St., oakland, Md 21550 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory srreat, shock, or heart failure. List only one ceuse on aach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Carcinoma of Stomach | approximate since Dx |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers Dementia

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| H Johnson | D5333 | ▶ 8/28/89 |

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Thomas Johnson, MD 311 N. 4th Street Oakland, Maryland 21550

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 30 '89 | Julia Davidson Rodgers |

14

DHMH-18 Rev 1/89

89 25869

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary Catherine RYAN | | | 2. DATE OF DEATH (Month, Day, Year): September 2, 1989 | 3. TIME OF DEATH: 8:15 a M |
| 4. SOCIAL SECURITY NUMBER: 582-98-0016 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): April 19 1900 | 8. BIRTHPLACE (State or Foreign Country): Colorado |
| 9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | 9c. COUNTY OF DEATH: Garrett | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Rockville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 11121 Luxmanor Road | | 10f. ZIP CODE: 20852 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant | 16b. KIND OF BUSINESS/INDUSTRY: US Government | | |
| 17. FATHER'S NAME (First, Middle, Last): Martin J. McCarthy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Frances McGuire | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary D. Ryan | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11121 Luxmanor Rd. Rockville, Md. 20852 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | 20c. LOCATION — City or Town, State: Silver Spring, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert H. Durst M00167 | 22. NAME AND ADDRESS OF FACILITY: P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Ischemic Heart Disease | 12 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Arteriosclerotic Cardio-Vascular Disease | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO X | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Herbert H. Leighton MD | 29c. LICENSE NUMBER: D 05658 | 29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 2, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Herbert H. Leighton, M.D., Oak @ 5th Sts., Oakland, Maryland 21550

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 5 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall |

3

DNMH-16 Rev 1/89

89 25870

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leona Pearl SKIPPER | | 2. DATE OF DEATH (Month, Day, Year): Sept. 2, 1989 | 3. TIME OF DEATH: 911 P M |
| 4. SOCIAL SECURITY NUMBER: 216-38-1867 | 5. SEX: 1 ☐ M 2 ☒ F | 5. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 7, 1903 |
| 8. BIRTHPLACE (State or Foreign Country): West Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Oakland | 9c. COUNTY OF DEATH: Garrett | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Oakland | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 5, Box 233 | 10f. ZIP CODE: 21550 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): Raymond ----- Winters | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella ----- Hauser | | |
| 19a. INFORMANT'S NAME (Type/Print): Lawrence E. Skipper | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 4, Box 43, Deer Park, Maryland 21550 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oakland Cemetery | 20c. LOCATION — City or Town, State: Oakland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOpulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Donald R Richter MD | 29c. LICENSE NUMBER: D30035 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald R. Richter, MD 311 N. Fourth St., Oakland, Maryland 21550 | | |
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kimball | |

DHMH-16 Rev 1/89

89 25810

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Howard Ray Cline (Howard Ray Cline) | | | 2. DATE OF DEATH Month: 9 Day: 8 Year: 89 | 3. TIME OF DEATH: 11 50 P M |
| 4. SOCIAL SECURITY NUMBER: 218-14-1132 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 9, 1924 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Fallston | | 9c. COUNTY OF DEATH: Harford |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: 1905 Park Beach Drive, Aberdeen | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1905 Park Beach Drive | | 10f. ZIP CODE: 21001 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Rigger | 16b. KIND OF BUSINESS/INDUSTRY: US-government | |
| 17. FATHER'S NAME (First, Middle, Last): James Gordon Cline | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clementine --- Parks | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia A. Cline | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1905 Park Beach Drive, Aberdeen, Md. 21001 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | 20c. LOCATION — City or Town, State: Bel Air, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III | | 22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Aspiration Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. General debilitation / Seizures | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. Metastatic Renal cell Carcinoma | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Smith | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Robert L Smith MD - Fallston Gen. Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25872
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Virginia Jennie Gillespie
2. DATE OF DEATH: MONTH 9 DAY 1 YEAR 89
3. TIME OF DEATH: 4:20 AM
4. SOCIAL SECURITY NUMBER: 215-24-7882
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-23-~~89~~20
8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): 566 Lewis St.
9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Havre de Grace
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 556 Lewis St.
10f. ZIP CODE: 21078
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— II yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Reese Gallimore
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Lillian -----
19a. INFORMANT'S NAME (Type/Print): Thelma Gordan
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6617 English Oaks Rd. Towson, MD. 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union United Methodist
20c. LOCATION — City or Town, State: Aberdeen, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Arnold W. Beard
22. NAME AND ADDRESS OF FACILITY: Arnold W. Beard Funeral Service Havre de Grace. MD 21078

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aspiration Pneumonia | 2 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CVA | 2 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Howlett Jackson M.D.
29c. LICENSE NUMBER: D20993
29d. DATE SIGNED (Month, Day, Year): ▶ 9-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howlett Jackson M.D. 3073 Union Ave Havre de Grace Md 21078
31. DATE FILED (Month, Day, Year): SEP 11 '89
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 25873

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Esther M. Knight | | 2. DATE OF DEATH (Month, Day, Year): Sept. 11, 1989 | 3. TIME OF DEATH: 9:42 A M |
| 4. SOCIAL SECURITY NUMBER: 159 34 4181 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (If yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 09-24-1904 |
| 8. BIRTHPLACE (State or Foreign Country): MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace | 9c. COUNTY OF DEATH: Harford | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Havre de Grace | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 320 Fox Road | | 10f. ZIP CODE: 21078 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) District Supervisor | 18b. KIND OF BUSINESS/INDUSTRY: Philadelphia Dep of Rec. |
| 17. FATHER'S NAME (First, Middle, Last): H. Archer Knight | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Sitzler | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Rodney B. Jones | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Oak Ave., Pikesville, MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): R. A. Ferris + Company | 20c. LOCATION — City or Town, State: West Chester, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William S. Smith | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COPD — 12 YRS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. POSSIBLE SMALL BOWEL OBSTRUCTION

DUE TO (OR AS A CONSEQUENCE OF):

c. due ~~to~~ either to surgical adhesions or

DUE TO (OR AS A CONSEQUENCE OF):

d. porolytic ileus secondary to infect—

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Louis Silverstein MD | 29c. LICENSE NUMBER: 027154 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LOUIS SILVERSTEIN MD P.O. BOX 8 HAVRE DE GRACE, MD 21078 | | |
| 31. DATE FILED (Month, Day, Year): SEP 14 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25874

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Cora B Sage | | | 2. DATE OF DEATH (Month, Day, Year): 8 28 89 | 3. TIME OF DEATH: 1245 PM |
| 4. SOCIAL SECURITY NUMBER: 220--14--4032 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DE. 18, 1912 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace | | 9c. COUNTY OF DEATH: Harford |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: CECIL | 10c. CITY, TOWN OR LOCATION: RISING SUN | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO XX |
| 10e. STREET AND NUMBER: 87 POST ROAD | | 10f. ZIP CODE: 21911 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO XX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO XX Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOSPITAL AID | | 16b. KIND OF BUSINESS/INDUSTRY: VA HOSPITAL |
| 17. FATHER'S NAME (First, Middle, Last): JIM BONHAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA SAGE | | |
| 19a. INFORMANT'S NAME (Type/Print): LOUIS SAGE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 87 POST ROAD, RIAING SUN, MD 21911 | | |
| 20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOPEWELL CEMETERY | 20c. LOCATION — City or Town, State: PORT DEPOSIT, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard L. Goodie | 22. NAME AND ADDRESS OF FACILITY: R.T. FOARD FUNERAL HOME RISING SUN, MARYLAND 21911 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure & Pleural effusion | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): A.S.C.V.D | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(2) C.O.P.D.
(3) Chronic Brain Syndrome due to Senility
(4) Hypothyroidism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| E.C. Loop, M.D. | D 5676 | ▶ 8/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E.C. Loo, MD 319 S. Union Ave., Havre de Grace, Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 30 '89 | Julia Tuttle Randall |

DHMH-16 Rev 1/89

89 25875

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
| GOLDIE Peterson (Bryan) Norris | | | Sept. 4 89 | 9:20 A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) |
| 214-24-9150 | 1 ☐ M 2 ☒ F | 81 YRS. | | 11-01-07 |

8. BIRTHPLACE (State or Foreign Country): .

9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital 200 Milton Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Fallston Md.
9c. COUNTY OF DEATH: Harford.

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland. | Harford | Forest Hill Maryland. | 1 ☐ YES 2 ☒ NO |

10e. STREET AND NUMBER: 203 W Jarrettsville Road
10f. ZIP CODE: 21050
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: .
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Cashier Unemployed | Cashier- Banking Banking |
| 11 | 2 | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John William Peterson | Grace Lee DeBow |

| 19a. INFORMANT'S NAME (Type/Print) 838-5793 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. William C. Norris, Jr. | 207 W. Jarrettsville Rd., Forest Hill, Md. 21050 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt Tabor Cemetery | Bel Air, Md. 21014 |

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph W. Foster
22. NAME AND ADDRESS OF FACILITY: Foster Funeral Home, 50 W. Broadway & Williams St., Bel Air, Maryland 21014

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. End stage Cardiac disease | many |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): ASCVD, Cardiac arrhythmia | yrs. |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Severe malnutrition | Months |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D-16444 | ▶ 9-9-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. S. NAIR M.D. 2112 Belair Road-Fallston

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1041

Items:23 thru 28f per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25876 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH / DAY / YEAR | 3. TIME OF DEATH |
|---|---|---|---|---|
| Scott | E. | Pauley Jr. | 9/9/89 | 11:45A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215 54 1207 | 1 [X] M 2 [ ] F | 39 YRS. | | | 02-15-1950 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 203 S. Washington | Havre de Grace | Harford |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Harford | Havre de Grace | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 205 S. Washington Street, Apt #4 | 21078 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [X] YES 2 [ ] NO — Vietnam | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4 or 5 +) | | |
| 12th | | Clerk Typist | Federal Government |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Scott E. Pauley, Sr. | Virginia Tibbs |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Virginia L. Pauley | 100 Revolution Street, Havre de Grace, MD 21078 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | R. A. Ferris + Co. | West Chester, PA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Diltiazem and Ethanol Intoxication DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV Test Positive and Arteriosclerotic Cardiovascular Disease

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [X] NO | Subject used drugs and alcoho |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 205 S. Washington Havre DeGrace, Harford, Md. |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James A. Kaplan, M.D. | OCME | ▶ 9/10/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
|---|---|---|
| James A. Kaplan, M.D. | 111 Penn St. | Balto., Md. 21201 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 19 '89 | Julia Davidson-Randall |

DHMH-15 Rev 1/89

89 25816

89 25877

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SCOTT E. PAULEY SR.
2. DATE OF DEATH: MONTH 9 DAY 12 YEAR 89
3. TIME OF DEATH: 2 45 M
4. SOCIAL SECURITY NUMBER: 224-18-4923
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-22-20
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 455 Lafayette St
9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Havre de Grace
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 455 Lafayette Street
10f. ZIP CODE: 21078
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Laborer
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Charles Pierce Pauley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Bell Lampert
19a. INFORMANT'S NAME (Type/Print): Mrs. Virginia L. Pauley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Revolution Street, Havre de Grace, MD 21078
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens
20c. LOCATION — City or Town, State: Aberdeen, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William L. Smith II
22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. arteriosclerotic Cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: alcoholism

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard J. Colfer
29c. LICENSE NUMBER: DO 1194
29d. DATE SIGNED (Month, Day, Year): 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD J. COLFER M.D. 2913 Taylor Church Rd. Darlington, Md
31. DATE FILED (Month, Day, Year): SEP 13 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Francis G Turner | | | 2. DATE OF DEATH: Month 8, Day 17, Year 89 | 3. TIME OF DEATH: 7 30 PM |
| 4. SOCIAL SECURITY NUMBER: 223 18 6548 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 02-26-1922 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace | 9c. COUNTY OF DEATH: Harford | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Havre de Grace | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1406 Bay View Drive | 10f. ZIP CODE: 21078 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Self-Employed | 16b. KIND OF BUSINESS/INDUSTRY: Dry Cleaning Business | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Turner | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Pitts | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Jeanne C. Turner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1406 Bay View Drive, Havre de Grace, MD 21078 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens | 20c. LOCATION — City or Town, State: Aberdeen, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William S Smith | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, Maryland 21078 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute myocardial infarction | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cardiac arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Ischemic encephalopathy | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 8 [ ] Residence 8 [ ] Other (Specify)

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Brian T. Yee M.D | 29c. LICENSE NUMBER: D15152 | 29d. DATE SIGNED (Month, Day, Year): 8/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): AUG 21 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lottie Evelyn Takacs
2. DATE OF DEATH: MONTH 8 DAY 23 YEAR 89
3. TIME OF DEATH: 11 50 P M
4. SOCIAL SECURITY NUMBER: 216-18-1695
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-9-11
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Fallston
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Perry Hall
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3817 Schroeder Ave.
10f. ZIP CODE: 21128
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): George Purnell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary UNK
19a. INFORMANT'S NAME (Type/Print): Mr. Alfred F. Takacs
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3817 Schroeder Ave., Perry Hall, Md. 21128
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens
20c. LOCATION — City or Town, State: Aberdeen, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth B. Lange
22. NAME AND ADDRESS OF FACILITY: Tarring Funeral Home, P.A. TARRING & ABERDEEN MD 21001-3339

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adult Respiratory Distress Syndrome.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. End Stage Interstitial Pulm Fibrosis.

DUE TO (OR AS A CONSEQUENCE OF):

c. ASCVD.

DUE TO (OR AS A CONSEQUENCE OF):

d. CHF

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J. K. MD
29c. LICENSE NUMBER: BC0294710
29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.K. Lynch Bel Air, Md- 21014.
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edith T. Wardell | | | 2. DATE OF DEATH (Month, Day, Year): Aug 29 1989 | 3. TIME OF DEATH: 8 37 p M |
| 4. SOCIAL SECURITY NUMBER: 212-05-0314 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 7, 1911 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace | 9c. COUNTY OF DEATH: Harford | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Cecil | 10c. CITY, TOWN OR LOCATION: 85 Cherry Lane, Perryville 21903 | 10d. INSIDE CITY LIMITS? XX YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 85 Cherry Lane | | 10f. ZIP CODE: 21903 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Eleven Years; College (1-4 or 5+): ----- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chief Telephone Operator | 16b. KIND OF BUSINESS/INDUSTRY: C & P Telephone Company Aberdeen Exchange | |
| 17. FATHER'S NAME (First, Middle, Last): Roy Bell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Bryant | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Audrey Riale | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): COlora, Maryland 21917 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Asbury Cemetery | 20c. LOCATION — City or Town, State: Port Deposit, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lee A. Patterson, Sr. | | 22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home Perryville, Maryland | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. AS COPD - COPD | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Pelvic mass ? ovarian Ca | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Anemia, CHF | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): Bilateral cataract surgery | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES XX NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| J.T. Lee | D20661 | 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.T. Lee, M.D., 319 South Union Ave., Havre de Grace, Maryland 21078

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 31 '89 | Judith Hutchison-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE WIENER | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 8 / 89 | 3. TIME OF DEATH: 10:28 A.M. |
| 4. SOCIAL SECURITY NUMBER: 137 01 7671 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 09-25-1897 | 8. BIRTHPLACE (State or Foreign Country): NJ |
| 9a. FACILITY NAME (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE | | 9c. COUNTY OF DEATH: HARFORD |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: NJ | 10b. COUNTY: Union | 10c. CITY, TOWN OR LOCATION: Union | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 588 Andress Terr. | | 10f. ZIP CODE: 07083 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Head Cook | | 16b. KIND OF BUSINESS/INDUSTRY: AT + T |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Holler | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna | | |
| 19a. INFORMANT'S NAME (Type/Print): George Ruff | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Pebble Beach Ct., Toms River, NJ 08757 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Hevan | | 20c. LOCATION — City or Town, State: East Hanover, NJ |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William S. Smith, II | | 22. NAME AND ADDRESS OF FACILITY: McCracken Funeral Home Union, NJ 07083 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Edema

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John Yun | D12190 | 9/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN YUN M.D. 314 S. UNION AVE HAVRE DE GRACE MD 21078

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 13 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

Items:23,27 per ME G-656
10-18-89 cm

89 25882

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IF THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
IF THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| WILLIAM | G. | DUNNE | 8 / 24 / 89 | 2:37 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-84-2645 | 1 [X] M 2 [ ] F | 31 YRS. | | | May 22, 1958 | Washington DC |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | PG | Camp Springs | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5105 Freeman Drive | 20748 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 0 | 0 | N/A | N/A |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Richard G. Dunne | Kathryn F. Woody |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard G. Dunne | Same as 10a-10f. |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cem. | Suitland,Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Mat D. Poole | Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Maryland 20735 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrhythmai | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes, M.D. | OCME | ▶ 8-24-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
|---|---|---|
| Charles P. Kokes, M.D. | 111 Penn Street | Baltimore, MD 21201 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 07 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25883

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward Louis Hampl | | 2. DATE OF DEATH (Month, Day, Year): 9 - 3 - 89 | 3. TIME OF DEATH: 4.50A M |
| 4. SOCIAL SECURITY NUMBER: 505-16-3466 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/12/17 |
| 8. BIRTHPLACE (State or Foreign Country): Peague, Neb. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Howard County Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Columbia | 9c. COUNTY OF DEATH: Howard | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Mt. Rainier | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3003 Bunker Hill Road | 10f. ZIP CODE: 20712 | 10g. CITIZEN OF WHAT COUNTRY: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 ; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Poole's Warehousing | |
| 17. FATHER'S NAME (First, Middle, Last): Bohumil Hampl | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Dressler | | |
| 19a. INFORMANT'S NAME (Type/Print): Anne R. Hampl | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3003 Bunker Hill Road, Mt. Rainier, MD 20712 | | |
| 20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | 20c. LOCATION — City or Town, State: Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark A Barbour | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ischemic Cardiomyopathy. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L M. Zumiga 1101 maiden choice Lane Balt MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

(10) (IVA)

88 52883

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25884 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRISON JOHNSON | | | | 2. DATE OF DEATH (Month 9, Day 10, Year 89) | 3. TIME OF DEATH: 5 52 AM |
| 4. SOCIAL SECURITY NUMBER: 231-01-0629 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): February 7, 1919 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Columbia | | 9c. COUNTY OF DEATH: Howard |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Landover, Maryland | | | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1519 Bellehaven Drive | | 10f. ZIP CODE: 20785 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister | | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): William Henry Johnson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virgie Mary Parker | | | |
| 19a. INFORMANT'S NAME (Type/Print): Larry Martin Johnson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10e | | | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LincolnCemetery | | 20c. LOCATION — City or Town, State: Portsmount, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: 389 R.I. AvenueN.W. Frazier's Funeral Home Washington, D.C. 20001 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | 12h |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic cervical myelopathy

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Scott T Maurer MD | 29c. LICENSE NUMBER: D29903 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SCOTT T MAURER 10772 HICKORY RIDGE RD COLMD 21044

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25885

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JACQUELINE MOTLEY | | | | 2. DATE OF DEATH (Month, Day, Year): AUG 31 1989 | 3. TIME OF DEATH: 6:38 PM |
| 4. SOCIAL SECURITY NUMBER: 167-32-3336 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 50 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): November 21, 1938 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Columbia | | 9c. COUNTY OF DEATH: Howard |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: New York | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Middletown | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4 Peace Drive | | 10f. ZIP CODE: 10940 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+): 4years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher | | 16b. KIND OF BUSINESS/INDUSTRY: School System | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Hunter | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Zefferie Crawford | | | |
| 19a. INFORMANT'S NAME (Type/Print): Donald Motley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10e | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carolina Biblical Gardens | 20c. LOCATION — City or Town, State: Greensboro, North Carolina | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. J. Jeffers | 22. NAME AND ADDRESS OF FACILITY: 389 R.I. Ave, N.W. Frazier's Funeral Home Washington, D.C. 20001 | | | | |

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULMONARY ARREST | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. HEPATIC FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. AIDS & PANCYTOPENIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic diarrhea

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D17107 | 8/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEBREYE W. RUFAEL, 10840 LITTLE PATUXENT PKY. Columbia, MD 21044

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

(12)

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Vesta Natalie McComas | | 2. DATE OF DEATH (Month, Day, Year): August 4, 1989 | 3. TIME OF DEATH: 10:15PM |
| 4. SOCIAL SECURITY NUMBER: 216-13-6901 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/25/1896 |
| 8. BIRTHPLACE (State or Foreign Country): New Jersey | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Annes Hospital Inc. | 9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown | 9c. COUNTY OF DEATH: Kent | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Queen Anne | 10c. CITY, TOWN OR LOCATION: Centreville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Corsica Hills | 10f. ZIP CODE: 21617 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse | 16b. KIND OF BUSINESS/INDUSTRY: Health Care | |
| 17. FATHER'S NAME (First, Middle, Last): William Markel | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Adelia | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Frances Crane | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 142, Sudlersville MD 21668 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Templeville Cemetery | 20c. LOCATION — City or Town, State: Templeville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home P.O. Box 160, Greensboro, MD 21639 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Chronic Obstructive Lung Disease with Exacerbation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Dehydration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Electrolyte imbalance | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Arteriosclerotic Heart Disease ② Chronic Abd. Pain ③ Cervical & Lumbar Degenerative arthritis with radiculopathy ④ Peripheral Arterial Disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify); 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H.H. Winn, MD. | 29c. LICENSE NUMBER: D21313 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/14/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KIN K. WIN, 216 High St, Chestertown, Md. 21620 | | |
| 31. DATE FILED (Month, Day, Year): AUG 21 89 | 32. REGISTRAR'S SIGNATURE: Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bernice F. Ashe — BERNICE F. ASHE | | | 2. DATE OF DEATH (Month, Day, Year): 8 27 89 | 3. TIME OF DEATH: 4:03 AM M |
| 4. SOCIAL SECURITY NUMBER: 238-58-8659 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 1, 1906 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring, Maryland | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: North Carolina | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Rich Square, North CArolina | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 825 Bryantown Road | | 10f. ZIP CODE: 27869 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Negro |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8 +): College Degree | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: School System |
| 17. FATHER'S NAME (First, Middle, Last): Frank Stewart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie DeLoatch | |
| 19a. INFORMANT'S NAME (Type/Print): Frank Stewart Ashe, Son | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3854 Bel Pre Rd #7, Silver Spring Maryland 20906 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ashe Family Cemetery | 20c. LOCATION — City or Town, State: Rich Square, N. C. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Johnson & Jenkins 716 Kennedy St N.W. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac-Respiratory Failure & Arrest | 20 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute Myocardial Infarction | 20 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Arteriosclerosis | ? years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Generalized Arteriosclerosis | ? years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Carotid arteriosclerosis with Stenosis Post-operative Right Carotid endarterectomy

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|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Marvin L. Kolkin, M.D. ▶ | 29c. LICENSE NUMBER: D-06033 | 29d. DATE SIGNED (Month/Day, Year) ▶ 8/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marvin L. Kolkin, M. D. 18111 PRINCE PHILIP DRIVE, OLNEY, MD 20832

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen F Berryman | | | 2. DATE OF DEATH (Month, Day, Year): September 8, 1989 | 3. TIME OF DEATH: 9:00 AM |
| 4. SOCIAL SECURITY NUMBER: 376-54-8248 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 5, 1908 | 8. BIRTHPLACE (State or Foreign Country): Mexico |
| 9a. FACILITY NAME (If not institution, give street and number): 1511 Auburn Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Rockville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1511 Auburn Avenue | | 10f. ZIP CODE: 20850 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: High School | |
| 17. FATHER'S NAME (First, Middle, Last): John Henry Pengelly | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Trengove | |
| 19a. INFORMANT'S NAME (Type/Print): Beatrice B. Marie | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1511 Auburn Avenue, Rockville, Maryland 20850 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | 20c. LOCATION — City or Town, State: Bethesda, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] M00689 | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc, 300 West Montgomery Ave. Rockville, Maryland | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute respiratory arrest | Sudden |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic obstructive pulmonary disease | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary heart disease, Cor pulmonale, Dementia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. | 29c. LICENSE NUMBER: DO 1193 | 29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sidney J. Cohen, M.D. 121 Congressional Ln. #402 Rockville, Maryland

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: [signature] |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sue Jeanette Bowen | | | 2. DATE OF DEATH (Month, Day, Year): 9 7 89 | 3. TIME OF DEATH: 3:32 PM |
| 4. SOCIAL SECURITY NUMBER: 577-40-6733 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 62 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): October 31, 1926 | 8. BIRTHPLACE (State or Foreign Country): Rosehill, ~~North Carolina~~ |
| 9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park | | 9c. COUNTY OF DEATH: Montgomery County |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's County | 10c. CITY, TOWN OR LOCATION: Cheverly | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2605 Valley Way | | 10f. ZIP CODE: 20785 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): -------- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Title Clerk | | 16b. KIND OF BUSINESS/INDUSTRY: Banning Motors |
| 17. FATHER'S NAME (First, Middle, Last): Leary Thomas Alderman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ludie Mabelle Alderman | | |
| 19a. INFORMANT'S NAME (Type/Print): Melvin U. Bowen (Husband) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2605 Valley Way, Cheverly, Maryland 20785 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | | 20c. LOCATION — City or Town, State: Brentwood, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy Brohawn | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 3 Wks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Squamous Cell Carcinoma of Trachea | 2 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Thomas A. Bensinger MD | D08754 | ▶ 9/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas A. Bensinger, MD 7525 Greenway Ctr Dr. Greenbelt MD 20770

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julie Davidson-Randall |

DHMH-16 Rev 1/89

89 25890

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ~~Margaret Ethel Betts~~ MARGARET ETHEL BETTS

**2. DATE OF DEATH** (Month, Day, Year): 9 4 89

**3. TIME OF DEATH**: 11 P M

**4. SOCIAL SECURITY NUMBER**: 577-26-2437

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 94 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Sept. 15, 1894

**8. BIRTHPLACE** (State or Foreign Country): Wash., D.C.

**9a. FACILITY NAME** (If not institution, give street and number): Manor Care Potomac

**9b. CITY, TOWN OR LOCATION OF DEATH**: Potomac

**9c. COUNTY OF DEATH**: Montgomery

**RESIDENCE OF DECEDENT**

**10a. STATE**: ---

**10b. COUNTY**: ---

**10c. CITY, TOWN OR LOCATION**: Washington, D.C.

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 4911 - 46th Street, N.W.

**10f. ZIP CODE**: 20016

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 7

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Supervisor

**16b. KIND OF BUSINESS/INDUSTRY**: Federal Gov't.

**17. FATHER'S NAME** (First, Middle, Last): William Taylor Betts

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Lucille Robinson

**19a. INFORMANT'S NAME** (Type/Print): Walter L. Smith

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8006 Brown Bark Pl., Raleigh, NC 27615

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Rock Creek Cemetery

**20c. LOCATION — City or Town, State**: Washington, D.C.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Michael E. Nelson

**22. NAME AND ADDRESS OF FACILITY**: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Wash., D.C.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MYOCARDIAL INFARCTION | 15 MIN. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | CORONARY ARTERY DISEASE | YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PRIOR STROKE
DIABETES MELLITUS

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature]

**29c. LICENSE NUMBER**: D09764

**29d. DATE SIGNED** (Month, Day, Year): ▶ 9-5-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): JOEL A. RASKIN, MD 50 W. EDMONSTON DR., ROCKVILLE, MD

**31. DATE FILED** (Month, Day, Year): SEP 08 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson Rodell

DHMH-16 Rev 1/89

20

89 25891

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): VIRGINIA M. CABLE

**2. DATE OF DEATH** Month: 9 Day: 4 Year: 89

**3. TIME OF DEATH**: 2050 M

**4. SOCIAL SECURITY NUMBER**: 212-24-4860

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 59 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 2-17-30

**8. BIRTHPLACE** (State or Foreign Country): Tennessee

**9a. FACILITY NAME** (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: ROCKVILLE, MD.

**9c. COUNTY OF DEATH**: MONTGOMERY

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Montgomery

**10c. CITY, TOWN OR LOCATION**: Gaithersburg

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 511 S. Frederick Avenue, #17

**10f. ZIP CODE**: 20877

**10g. CITIZEN OF WHAT COUNTRY?**: United States

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 0

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Waitress

**16b. KIND OF BUSINESS/INDUSTRY**: Restaurant

**17. FATHER'S NAME** (First, Middle, Last): Percy Yokley

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Minnie Brown

**19a. INFORMANT'S NAME** (Type/Print): Ronald R. Lowe

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1744 Springfield Lane, Frederick, Maryland 21701

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Arlington National Cemetery

**20c. LOCATION — City or Town, State**: Arlington, Virginia

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Barbara Jo McMullen Lawrence M00381

**22. NAME AND ADDRESS OF FACILITY**: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Sepsis — 9 Days
DUE TO (OR AS A CONSEQUENCE OF):
c. Respiratory Failure — Yrs
DUE TO (OR AS A CONSEQUENCE OF):
d. Congestive Heart Failure — Yrs

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Edward J Davin MD

**29c. LICENSE NUMBER**: D33677

**29d. DATE SIGNED** (Month, Day, Year): ▶ 9/4/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Edward J Davin, MD 19721 Executive Park Circle Germantown MD 20874

**31. DATE FILED** (Month, Day, Year): 9/4/89 SEP 11 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25892
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER C. CLARKE
2. DATE OF DEATH (Month, Day, Year): Sept. 3, 1989
3. TIME OF DEATH: 6:12 PM M
4. SOCIAL SECURITY NUMBER: 577-05-8148
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 29, 1905
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Collingwood Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 15320 Pine Orchard Drive
10f. ZIP CODE: 20906
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2 years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Real Estate
16b. KIND OF BUSINESS/INDUSTRY: Self Employed
17. FATHER'S NAME (First, Middle, Last): George F. Clarke
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marin Clowes
19a. INFORMANT'S NAME (Type/Print): Marcia C. Sims
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15320 Pine Orchard Drive, Silver Spring, Md. 20906
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rock Creek Cemetery
20c. LOCATION — City or Town, State: Washington, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clark E Wesa
22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home, 11800 N.H. Ave., Silver Spring, Md. 20904

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Uremia | Months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Multiple Myeloma | 11 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Myocardiopthy requiring pacemaker | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | implantation secondary to Multiple Myeloma Mentor | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gustavo S. Belaval, MD
29c. LICENSE NUMBER: 015741
29d. DATE SIGNED (Month, Day, Year): 5 Sep. 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gustavo Belaval, MD 3701 Rossmoor Blvd., Silver Spring, Md. 20906
31. DATE FILED (Month, Day, Year): SEP 7 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

25

DHMH-16 Rev 1/89

89 2585

89 25893

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ETTA COOPERMAN | | | 2. DATE OF DEATH (Month, Day, Year): 9/4/89 | 3. TIME OF DEATH: 9 05 P.M. |
| 4. SOCIAL SECURITY NUMBER: 050-22-1664 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 99 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DEC. 25, 1889 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE | | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: ROCKVILLE | 10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6121 MONTROSE RD. | | 10f. ZIP CODE: 20852 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JACOB HOCHBERG | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): JAMES JAFFE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2717 38th ST. N.W., WASH. D.C. 20007 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHAMBERS CREMATORY | 20c. LOCATION — City or Town, State: RIVERDALE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. W. Chambers M00091 | | 22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. 517 11th ST. S.E. WASH. D.C. 20003 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CHRONIC HEART FAILURE | >10 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC HEART DISASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MULTI-INFARCT DEMENTIA

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Staff Physician | 29c. LICENSE NUMBER: D 15084 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. D. PATEL, 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | |
| 31. DATE FILED (Month, Day, Year): SEP 7, '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 25894

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALICE DODSON | | 2. DATE OF DEATH (Month / Day / Year): 9 / 6 / 89 | 3. TIME OF DEATH: 1634 M |
| 4. SOCIAL SECURITY NUMBER: 217-24-7852 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-7-19 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSP | 9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK | 9c. COUNTY OF DEATH: MONTGOMERY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Howard | 10c. CITY, TOWN OR LOCATION: Laurel | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 9315 All Saints Road | 10f. ZIP CODE: 20707 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Ernest Lewis | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Sampson | | |
| 19a. INFORMANT'S NAME (Type/Print): Leroy W. Dodson (husband) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9315 All Saints Rd., Laurel, MD 20707 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Queens Chapel Cemetery | 20c. LOCATION — City or Town, State: Beltsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden | 22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home, P.A. Rockville, MD 20850 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PULMONARY INSUFFICIENCY - RENAL | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. FAILURE & SEPSIS. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. G.I. Bleeding - Coronary Artery Disease | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Neurological deficit.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Samir Negmat M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMIR R. NEGMAT, M.D. 7610 CARROLL AV. TAKOMA PARK, MD, 20912

31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

5

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25895 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEOENT'S NAME** (First, Middle, Last): Roland E. Dulin — ROLAND ERNEST DULIN

**2. DATE OF DEATH** (Month, Day, Year): 9 9 89

**3. TIME OF DEATH**: 8 [illegible] M

**4. SOCIAL SECURITY NUMBER**: 126-22-6543

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Feb 21, 1906

**8. BIRTHPLACE** (State or Foreign Country): Washington, DC

**9a. FACILITY NAME** (If not institution, give street and number): Manor Care Potomac

**9b. CITY, TOWN OR LOCATION OF DEATH**: Potomac

**9c. COUNTY OF DEATH**: Montgomery

**RESIDENCE OF DECEDENT**

**10a. STATE**: ---

**10b. COUNTY**: ---

**10c. CITY, TOWN OR LOCATION**: Washington, DC

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 4201 Cathedral Av. NW

**10f. ZIP CODE**: 20016

**10g. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

**12. WAS DECEOENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: World War II

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +): 4

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Officer

**16b. KIND OF BUSINESS/INDUSTRY**: U. S. Foriegn Service

**17. FATHER'S NAME** (First, Middle, Last): James Ernest Dulin

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Lulu Selby

**19a. INFORMANT'S NAME** (Type/Print): Bernard Reichhardt

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2220 Wheelright Ct., Reston, VA 22091

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Cedar Hill Cemetery

**20c. LOCATION — City or Town, State**: Suitland, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Michael J. Nelson

**22. NAME AND ADDRESS OF FACILITY**: Joseph Gawler's Sons
5130 Wisconsin Av., Washington, DC 20016

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. UROSEPSIS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
Biliary stone disease
GI bleeding per rectum

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Philip Schwartz MD Philip Schwartz

**29c. LICENSE NUMBER**: MARYLAND D24398

**29d. DATE SIGNED** (Month, Day, Year): 9-9-89 1015P

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)
15225 Shady Grove ROAD Suite 206 Rockville, MD 20850 Phone 330-0550

**31. DATE FILED** (Month, Day, Year): SEP 11 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25896

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Vivian Dolores DeVor | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 5, 1989 | 3. TIME OF DEATH: 1:40am M |
| 4. SOCIAL SECURITY NUMBER: 189-22-6610 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): August 18, 1929 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 13018 Grenoble Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Rockville, | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 13018 Grenoble Drive | | 10f. ZIP CODE: 20853 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Clarence E. Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Olive M. Welling | |
| 19a. INFORMANT'S NAME (Type/Print): Leonard L. DeVor | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13018 Grenoble Drive, Rockville, Maryland 20853 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park | 20c. LOCATION — City or Town, State: Rockville,Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George T Kephart M00335 | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Rockville, Inc, 300 West Montgomery Avenue Rockville, Maryland 20850 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Small Cell Lung Cancer | 1 Year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver, Bone, Bone Marrow, Lung Involvement
Cardiomyopathy

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NG

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural; 2 ☐ Accident; 3 ☐ Suicide; 4 ☐ Homicide; 5 ☐ Pending investigation; 8 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Donald E. Dillon MD | 29c. LICENSE NUMBER: D13832 | 29d. DATE SIGNED (Month, Day, Year): September 5, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald Dillon, M.D. 2910 Olney-Sandy Spring Road, Olney, Maryland 20832

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN A. DESCH | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 3, 1989 | 3. TIME OF DEATH: 6:30 P M |
| 4. SOCIAL SECURITY NUMBER: 577-12-3470 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DEC. 19, 1914 |
| 8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number): POTOMAC NURSING HOME | 9b. CITY, TOWN OR LOCATION OF DEATH: POTOMAC | 9c. COUNTY OF DEATH: MONTGOMERY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: WHEATON | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 11701 JUDSON ROAD | | 10f. ZIP CODE: 20902 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DRAFTSMAN | 16b. KIND OF BUSINESS/INDUSTRY: DEPT. OF TRANSPORTATION | |
| 17. FATHER'S NAME (First, Middle, Last): EMIL JOHANN DESCH | 18. MOTHER'S NAME (First, Middle, Maiden Surname): TECKLE F. STENGER | | |
| 19a. INFORMANT'S NAME (Type/Print): GRACE W. DESCH | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11701 JUDSON ROAD, WHEATON, MARYLAND 20902 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY | 20c. LOCATION — City or Town, State: SUITLAND, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J Boyle | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 2 wks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | 2 wks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Parkinson's disease | 6 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: George S Kenton, MD | 29c. LICENSE NUMBER: D 08695 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE S. KENTON, MD 10620 GEORGIA AVE, SILVER SPRING, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Miriam Ethel Frank | 2. DATE OF DEATH (Month, Day, Year): Aug 26 '89 | 3. TIME OF DEATH: 7:25 PM | |
| 4. SOCIAL SECURITY NUMBER: 217-30-1192 | 5. SEX: 1 ☐ M 2 XX F | 6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 26, 1906 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1316 Fenwick Lane Apt 1405 — RESIDENCE OF DECEDENT | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | 9c. COUNTY OF DEATH: Montgomery | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spring | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1316 Fenwick Lane, #1405 | 10f. ZIP CODE: 20910 | 10g. CITIZEN OF WNAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Morris Schlum | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Small | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert I. Frank (Son) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 328 Harvard Street--Rear; Cambridge, Mass. 02139 | | |
| 20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hebrew Friendship Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary M. Rice | 22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Dis. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
- b. DUE TO (OR AS A CONSEQUENCE OF):
- c. DUE TO (OR AS A CONSEQUENCE OF):
- d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D09975 | 29d. DATE SIGNED (Month, Day, Year): Aug 27 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): | | |
| 31. DATE FILED (Month, Day, Year): SEP 6 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25899

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jean S. FIROR (JEAN S. FIROR) | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 05 / 89 | 3. TIME OF DEATH: 3:35 PM |
| 4. SOCIAL SECURITY NUMBER: 215-44-7926 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 1, 1902 | 8. BIRTHPLACE (State or Foreign Country): Scotland. |
| 9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda, Montg. Co. | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland. | 10b. COUNTY: Montgomery. | 10c. CITY, TOWN OR LOCATION: Silver Spring. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1316 Fenwick Lane. | | 10f. ZIP CODE: 20910 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White. |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fed. Government Retired. FCC. | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Nathaniel Sloan. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jane Arthur. | |
| 19a. INFORMANT'S NAME (Type/Print): John V. Berberich # 3 | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 673 Evergreen Ave. Charlottsville, Va. 22901 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: ~~Washington D. C.~~ Suitland, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Julian S. Clark | | 22. NAME AND ADDRESS OF FACILITY: Takoma Funeral Home. Inc. 254 Carroll St. N. W. D. C. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aspiration pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cerebrovascular accident and | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypoxic encephalopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Alan S Chanales M.D. | 29c. LICENSE NUMBER: 29453 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALAN S. CHANALES 15225 SHADY GROVE RD ROCKVILLE 20850

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|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 6'89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FERNE OLINER FIELDS | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 8, 1989 | 3. TIME OF DEATH: 6:30 PM |
| 4. SOCIAL SECURITY NUMBER: 219-01-1639 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-25-1916 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 7425 DEMOCRACY BLVD. APT 307 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA | 9c. COUNTY OF DEATH: MONTGOMERY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: BETHESDA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7425 DEMOCRACY BLVD., APT. 307 | | 10f. ZIP CODE: 20817 | 10g. CITIZEN OF WHAT COUNTRY: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): ABRAHAM OLINER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ABRAMSON | |
| 19a. INFORMANT'S NAME (Type/Print): (SON) MR. LAURENCE FIELDS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 814 DIAMOND DR., GAITHERSBURG, MD 20878 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING DAVID MEM. GARDEN | 20c. LOCATION — City or Town, State: FALLS CHURCH, VIRGINIA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary M. Lise | | 22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MD | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. End Stage Emphysema. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus.
Depression.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul S. Rhodes MD | 29c. LICENSE NUMBER: D22028 | 29d. DATE SIGNED (Month, Day, Year): ▶ SEPT. 9, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL S. RHODES, M.D. 1902 R STREET, NW WASHINGTON, DC 20009 | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24

89 25300

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25901 REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DINAH FRIEDMAN | | 2. DATE OF DEATH Month: 9 Day: 9 Year: 89 | 3. TIME OF DEATH: 3:05 P.M. |
| 4. SOCIAL SECURITY NUMBER: 054-52-0212 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 97 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 3/3/92 |
| 8. BIRTHPLACE (State or Foreign Country): POLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME Of Gtr. Washington | 9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE, MD | 9c. COUNTY OF DEATH: MONTGOMERY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Rockville | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6121 Montrose Road | 10f. ZIP CODE: 20852 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Samuel Platt | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unobtainable | | |
| 19a. INFORMANT'S NAME (Type/Print): Norman Freedman (Son) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 University Blvd.,W,#708;Silver Spring,Md.20902 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Mt.Carmel Cemetery | 20c. LOCATION — City or Town, State: Glendale, New York | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary M. Gise | 22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASPIRATION | 1 hr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
STROKE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Carroll MD STAFF PHYSICIAN | 29c. LICENSE NUMBER: D 38392 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/9/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA CARROLL, MD, HEBREW HOME, 6121 ROCKVILLE, MD MONTROSE RD | | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 23901

89 25902

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HOWARD FRIEDMAN
2. DATE OF DEATH (Month, Day, Year): 09 02 89
3. TIME OF DEATH: 0800 A M
4. SOCIAL SECURITY NUMBER: 505-03-1174
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.)
7. DATE OF BIRTH (Month, Day, Year): 1-18-1914
8. BIRTHPLACE (State or Foreign Country): ILLINOIS
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: ROCKVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4708 OXBOW ROAD
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XXX YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW2
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN
16b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOYED
17. FATHER'S NAME (First, Middle, Last): ABRAHAM FRIEDMAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA KRANTZ
19a. INFORMANT'S NAME (Type/Print): SUSAN FRIEDMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4708 OXBOW ROAD:ROCKVILLE,MD 20852
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GARDEN
20c. LOCATION — City or Town, State: FALLS CHURCH, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael Krugler
22. NAME AND ADDRESS OF FACILITY: 1170 ROCKVILLE PIKE:ROCKVILLE,MD20852 DANZANSKY-GOLDBERG MEMORIAL CHAPELS

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. metastatic bladder carcinoma | 2 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Prostatic carcinoma

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Kathryn S. Kirwin MD
29c. LICENSE NUMBER: D26992
29d. DATE SIGNED (Month, Day, Year): ▶ 9/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KATHRYN S. Kirwin MD 10400 Conn Ave #606, Kensington, MD 20895
31. DATE FILED (Month, Day, Year): SEP 6 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 25903

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSEMARIE B. FRITZ | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 1 / 89 | 3. TIME OF DEATH: 1450 M | |
| 4. SOCIAL SECURITY NUMBER: 220-24-5255 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-15-28 | 8. BIRTHPLACE (State or Foreign Country): Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING | | 9c. COUNTY OF DEATH: MONTGOMERY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 12007 KEMP MILL ROAD | | 10f. ZIP CODE: 20902 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): EDWARD C. BRADY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET YEAGER | |
| 19a. INFORMANT'S NAME (Type/Print): ROLAND C. FRITZ, JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12007 KEMP MILL ROAD SILVER SPRING, MARYLAND 20902 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOW RIDGE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew J. Cole | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W. SIL.SPR.,MD.20901 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ea cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of lung — DUE TO (OR AS A CONSEQUENCE OF): | 2 yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST | b. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ernest Oser | 29c. LICENSE NUMBER: D03792 | 29d. DATE SIGNED (Month, Day, Year): 9/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IRNEST S. OSER, M.D. 10301 GEORGIA AVENUE SILVER SPRING, MARYLAND 20902

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 6'89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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89 2303

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25904

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|
| SARAH L. GREEN | SEPT 4 1989 | 5:25 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 181-20-0177 | 1 ☐ M 2 ☒ F XX | 69 YRS. | | | July 9, 1920 | Georgia |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2201 Colston Drive | 20910 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced XX | 1 ☐ YES 2 ☒ NO XX | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Supervisor | U.S. Government |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Gaines R. Brown | Mrytte Cornell |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kia Louise Garnett | 432 Branch Dr. Silver Spring, MD 20901 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | Rolling Green Cemetery | West Chester, PA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| John F Bolden | McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W. 20012 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | 20 MINUTES |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. VENTRICULAR FIBRILLATION | 21 MINUTES |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ~~CORO~~ CARDIOMYOPATHY | ONE YEAR |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CORONARY ARTERY DISEASE | ONE YEAR |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul Weinman MD | D23805 | ▶ 9/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
344 UNIVERSITY BLVD, W #213. SILVER SPRING, MD 20901

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 9/5/SEP 7 6'89 | Julia Davidson-Randall |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 181-20-0177 | xx | 69 | | July 9,1920 | Georgia | | |
| Suburban Hospital | | Bethesda | | | Montgomery | | |
| Maryland | Montgomery | Silver Spring | | | | x | |
| 2201 Colston Drive | | 20910 | | | United States | | |
| x | | x | x | | | Black | |
| 12 | | Supervisor | | | U.S. Government | | |
| Gaines R. Brown | | Mrytte Cornell | | | | | |
| Kia Louise Garnett | | 432 Branch Dr. Silver Spring, MD 20901 | | | | | |
| x | | | | | | | |
| | | Rolling Green Cemetery | | West Chester, PA | | | |
| | | McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W. 20012 | | | | | |

89 25905

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES HILL GRIM | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 11 1989 | 3. TIME OF DEATH: 3:45 AM |
| 4. SOCIAL SECURITY NUMBER: 228-02-3645 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 26 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-06-62 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 322 FRANKLIN AVENUE | 9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING | 9c. COUNTY OF DEATH: MONTGOMERY | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 322 FRANKLIN AVENUE | 10f. ZIP CODE: 20901 | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Association |
| 17. FATHER'S NAME (First, Middle, Last): Philip Henry Grim | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Thornton | |
| 19a. INFORMANT'S NAME (Type/Print): Robert A. Shelhorse | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 322 Franklin Avenue, Silver Spring, MD 20901 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory | 20c. LOCATION — City or Town, State: Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp | | 22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist avenue, Silver Spring, MD 20910 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. AIDS | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Kaposis Sarcoma, lungs, Deliated, Intensive | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Respiratory failure 2° to B | hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kaposis Sarcoma of bowel

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ruthann M. Giusti | R1 | ▶ 9/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ruthann M. Giusti, M. D., Clinical Center, 9000 Rockville Pike, Bethesda, MD 20205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 12 '89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CLARA F. GREENBERG | | 2. DATE OF DEATH (Month, Day, Year): September 3, 1989 | 3. TIME OF DEATH: 5:50 P. M |
| 4. SOCIAL SECURITY NUMBER: 577-34-1037 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 14, 1913 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Potomac Valley Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spring | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 15301 Pine Orchard Drive, #1-C | 10f. ZIP CODE: 20906 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Legal Secretary (Retired) | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Government |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Samuel Feldman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Katz |
| 19a. INFORMANT'S NAME (Type/Print): Melvin Feldman (Brother) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11707 Orebaugh Avenue; Silver Spring, Md. 20902 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): B'Nai Israel Cong. Cemetery | 20c. LOCATION — City or Town, State: Oxon Hill, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Larry M. Gruber | 22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple Myeloma | 10 mo. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bruce A. Silver, MD | 29c. LICENSE NUMBER: D21463 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce A. Silver MD 106 Irving St N.W. Wash. DC. 20010

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 6'89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DAVID R. GREEN | | | 2. DATE OF DEATH (Month, Day, Year): SEPT 08 1989 | 3. TIME OF DEATH: 6:45 P M |
| 4. SOCIAL SECURITY NUMBER: 260-32-7319 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): MAY 08 1929 | 8. BIRTHPLACE (State or Foreign Country): GEORGIA |
| 9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA | | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: PRINCE GEORGES | 10c. CITY, TOWN OR LOCATION: LAUREL | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6217 KAYBRO STREET | | 10f. ZIP CODE: 20707 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant | 16b. KIND OF BUSINESS/INDUSTRY: Vitro Laboratories | |
| 17. FATHER'S NAME (First, Middle, Last): ERNEST T. GREEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY L. BROCK | |
| 19a. INFORMANT'S NAME (Type/Print): MARCIA M. GREEN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6217 KAYBRO STREET, LAUREL, MD 20707 | |
| 20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery | 20c. LOCATION — City or Town, State: Arlington, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SMALL CELL CARCINOMA OF THE LUNG | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D-36734 | 29d. DATE SIGNED (Month, Day, Year): 7/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. A. THOMPSON, LT, MC, USN | NATIONAL NAVAL MEDICAL CENTER BETHESDA, MARYLAND 20814-5011 | |
| 31. DATE FILED (Month, Day, Year): SEP 13 89 | 32. REGISTRAR'S SIGNATURE: [signature] | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-25908

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): OLGA GAZELLA | | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 6, 1989 | Time of Death: 9 AM PM |
| 4. SOCIAL SECURITY NUMBER: 186-14-4338 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS — MIN. — | 7. DATE OF BIRTH (Month, Day, Year): JUNE 13, 1918 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring Md | | 9c. COUNTY OF DEATH: Montgomery | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: md | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 1111 UNIVERSITY BLVD. WEST, APT. 309 | | 10f. ZIP CODE: 20902 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS OECENOENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ADMINISTRATIVE ASST. | | 16b. KIND OF BUSINESS/INDUSTRY: DEPT. OF DEFENSE- GOV'T | |
| 17. FATHER'S NAME (First, Middle, Last): ANDREW GAZELLA | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BARNA | | | |
| 19a. INFORMANT'S NAME (Type/Print): MARTHA G. GREENLEAF | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 HERMLEIGH ROAD, SILVER SPRING, MARYLAND 20902 | | | |
| 20a. METHOO OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. CYRILS & METHEDIUS CEMETERY | | 20c. LOCATION — City or Town, State: OLYPHANT, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E Dooley | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD. 20901 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Carcinomatosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D08544 | 9/07/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN J. MERENDINO 4701 RANDOLPH ROAD #216, ROCKVILLE, MARYLAND 20852

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 8 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

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89 25909

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNIJA D. GALEJS | | | 2. DATE OF DEATH: MONTH 9 DAY 1 YEAR 1989 | 3. TIME OF DEATH: 10:45P M |
| 4. SOCIAL SECURITY NUMBER: 357-28-8477 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb.19,1930 | 8. BIRTHPLACE (State or Foreign Country): Riga Latvia |
| 9a. FACILITY NAME (If not institution, give street and number): 11736 Flints Grove Lane, | | 9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg | 9c. COUNTY OF DEATH: Montgomery | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD. | 10b. COUNTY: Montg. | 10c. CITY, TOWN OR LOCATION: Gaithersburg | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 11736 Flints Grove LA. | | 10f. ZIP CODE: 20878 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Scientist | 16b. KIND OF BUSINESS/INDUSTRY: Computer | |
| 17. FATHER'S NAME (First, Middle, Last): Ludvigs - Dunkuls | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alide - Kikutus | | |
| 19a. INFORMANT'S NAME (Type/Print): Sandra Galejs | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Browning RD. Somerville, Mass. 02145 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory | 20c. LOCATION — City or Town, State: Riverdale, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670 | | 22. NAME AND ADDRESS OF FACILITY: W.W.Chambers Co. Inc 9241 Columbia Blvd. Silver Spring, MD. 20910 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic alcoholism

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER - On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAMON ARISTIDES HERNANDEZ-CUE | | 2. DATE OF DEATH: MONTH 9 DAY 5 YEAR 89 | 3. TIME OF DEATH: 3 05 AM/PM M |
| 4. SOCIAL SECURITY NUMBER: 577-74-7110 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 62 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-01-27 |
| 8. BIRTHPLACE (State or Foreign Country): Guatemala | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | 9c. COUNTY OF DEATH: Montgomery | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MD | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Hyattsville | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1702 Hannon Street T2 | 10f. ZIP CODE: 20783 | 10g. CITIZEN OF WHAT COUNTRY? Guatemala | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: GUATEMALAN | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAINTENANCE WORKER | 16b. KIND OF BUSINESS/INDUSTRY: MONTGOMERY CO. SCHOOL SYS. | |
| 17. FATHER'S NAME (First, Middle, Last): ANSELMO HERNANDEZ | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE CUC DE HERNANDEZ | | |
| 19a. INFORMANT'S NAME (Type/Print): ANASTACIA A. HERNANDEZ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1702 HANNON STREET #T-2, HYATTSVILLE, MARYLAND 20783 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CALVARY CEMETERY | 20c. LOCATION — City or Town, State: SAN CRISTOBAL, GUATEMALA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan M Hawkins | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatorenal Syndrome | 3 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Liver Cirrhosis | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Metastatic Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Gastrointestinal Bleeding | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | MD BM1490628 | 9/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chaim Mond M.D. 10500 SUMMIT AVE., KENSINGTON, MD 20895

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 9/5 SEP 6 '89 | Julia Davidson-Randall |

DNMN-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Annie Wall Harman | | | 2. DATE OF DEATH (Month, Day, Year): September 6, 1989 | 3. TIME OF DEATH: 5:50 AM M |
| 4. SOCIAL SECURITY NUMBER: 223-92-7890 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 2, 1897 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Rockville Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | | 9c. COUNTY OF DEATH: Montgomery |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Chevy Chase | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4719 Dorset Avenue | | 10f. ZIP CODE: 20815 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Roper Baldwin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Eliza Patterson | | |
| 19a. INFORMANT'S NAME (Type/Print): George G. Harman, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4719 Dorset Avenue Chevy Chase, MD 20815 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | | 20c. LOCATION — City or Town, State: Bethesda, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert J Farrah M00198 | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | e. Cardio Respiratory Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Generalized Arteriosclerosis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John F. Tauber MD | D0854 6 | ▶ 9-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John F. Tauber, M.D. 8218 Wisconsin Avenue Bethesda, Maryland 20814

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 8 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Esther Halpert | | 2. DATE OF DEATH (Month / Day / Year): 09 / 09 / 89 | 3. TIME OF DEATH: 10:30 AM |
| 4. SOCIAL SECURITY NUMBER: 578-62-3405 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-14-00 |
| 8. BIRTHPLACE (State or Foreign Country): Hungary | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Hebrew Hm. of Greater Washington | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | 9c. COUNTY OF DEATH: Montgomery |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spgs. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1121 University Blvd. | 10f. ZIP CODE: 20902 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Chaim Heisler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Tehila Lachmanovich |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Nathan Halpert (SON) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11410 Empire Lane, Rockville, MD 20852 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Sholom Cong. Cemetery | 20c. LOCATION — City or Town, State: Capitol Heights, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mary M. Gise | 22. NAME AND ADDRESS OF FACILITY: Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, MD | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | 5 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. STROKE | 1 wk |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS; HYPERTENSION

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | N/A |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Carroll, MD STAFF PHYSICIAN | 29c. LICENSE NUMBER: D38392 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/9/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA CARROLL M.D. HEBREW HOME, 6105 MONTROSE RD ROCKVILLE, MD 20852 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25913

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mark C. Hannan | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 8 / 89 | 3. TIME OF DEATH: 4 38 pm M |
| 4. SOCIAL SECURITY NUMBER: 284126356 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-26-21 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda, MD | | 9c. COUNTY OF DEATH: Montgomery |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Bethesda | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5215 Acacia Ave. | | 10f. ZIP CODE: 20814 | | 10g. CITIZEN OF WHAT COUNTRY? United States |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [✓] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director of Research | | 16b. KIND OF BUSINESS/INDUSTRY: Newspaper |
| 17. FATHER'S NAME (First, Middle, Last): Michael C. Hannan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Rosalie McElroy | | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth Bury Hannan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5215 Acacia Avenue Bethesda, Maryland 20814 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | | 20c. LOCATION — City or Town, State: Silver Spring, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert J. Farrar M00198 | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | METASTATIC CARCINOMA | 2 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PANCREATIC CARCINOMA | 4 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO — 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Eugene P. Libre MD | D09470 | 8 Sept 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EUGENE P. LIBRE MD. 10400 CONNECTICUT AVENUE KENSINGTON MD. 20895

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

10+1

DHMH-18 Rev 1/89

89 22913

89 25914

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAEBELLE H. HAM | | 2. DATE OF DEATH (Month, Day, Year): 9 9 1989 | 3. TIME OF DEATH: 1055 P M |
| 4. SOCIAL SECURITY NUMBER: 577-05-0012 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Mar. 15, 1898 |
| 8. BIRTHPLACE (State or Foreign Country): Ohio | | | |
| 9a. FACILITY NAME (If not institution, give street and number): CARRIAGE Hill Nursing Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring, | 9c. COUNTY OF DEATH: Montgomery | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Chevy Chase | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2602 Ross Road | | 10f. ZIP CODE: 20815 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): yes | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney | 16b. KIND OF BUSINESS/INDUSTRY: Self employed | |
| 17. FATHER'S NAME (First, Middle, Last): Alexander Hunter | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lulu Gibb | |
| 19a. INFORMANT'S NAME (Type/Print): Phyllis C. Veihmeyer | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2602 Ross Road, Chevy Chase, Md. 20815 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Cemetery | 20c. LOCATION — City or Town, State: Rockville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Congestive Heart Failure | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Atherosclerosis | 1 year |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke
Pulmonary Tuberculosis
Atrial Fibrillation

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Steven F. Osborne, MD | 29c. LICENSE NUMBER: Maryland D30898 | 29d. DATE SIGNED (Month, Day, Year): 9/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2737 Devonshire Place NW Wash DC 20008 | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell | |

25

DHMH-18 Rev 1/89

89 2314

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25915
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): EDITH VIRGINIA HARVEY

**2. DATE OF DEATH** (Month, Day, Year): SEPT. 11, 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 222-10-7533

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 6-13-21

**8. BIRTHPLACE** (State or Foreign Country): Wash. DC

**9a. FACILITY NAME** (If not institution, give street and number): 14353 Georgia Ave., #101

**9b. CITY, TOWN OR LOCATION OF DEATH**: Silver Spring

**9c. COUNTY OF DEATH**: Montgomery

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Montgomery

**10c. CITY, TOWN OR LOCATION**: Silver Spring

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 14353 Georgia Ave., #101

**10f. ZIP CODE**: 20906

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +): 4

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Cook

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): John Millicent

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Leathere Jackson

**19a. INFORMANT'S NAME** (Type/Print): Carl Harvey (husband)

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14353 Georgia Ave., #101, Silver Spring, MD 20906

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Norbeck Memorial Park

**20c. LOCATION — City or Town, State**: Olney, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: George R. Snowden

**22. NAME AND ADDRESS OF FACILITY**: Snowden Funeral Home, P.A.
Rockville,MD 20850

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory insuffuency | 2 mo |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Small Cell Carcinoma of lung | 5 mo |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: Chronic Obstructive Lung Disease

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Jeremy V. Cooke MD

**29c. LICENSE NUMBER**: D 047602

**29d. DATE SIGNED** (Month, Day, Year): ▶ 9/11/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): 10400 Conn. Ave. Kensington Md.

**31. DATE FILED** (Month, Day, Year): SEP 12 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

12

DHMH-16 Rev 1/89

89 23915

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25916 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN V. JENKINS
2. DATE OF DEATH: MONTH 09 DAY 05 YEAR 89
3. TIME OF DEATH: 10:22 PM
4. SOCIAL SECURITY NUMBER: 579-20-0849
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 09 02 25
8. BIRTHPLACE (State or Foreign Country): TEXAS
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSP 1500 FOREST GLEN RD
9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: SILVER SPRING
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 11709 LEONA ST
10f. ZIP CODE: 20902
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 8 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BODY & FRAME TECHNICIAN
16b. KIND OF BUSINESS/INDUSTRY: SAFFORD LINCOLN MERCURY
17. FATHER'S NAME (First, Middle, Last): THOMAS V. JENKINS
18. MOTHER'S NAME (First, Middle, Maiden Surname): PAULINE BRAUTIGAM
19a. INFORMANT'S NAME (Type/Print): BEATRICE L. JENKINS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11709 LEONA STREET, SILVER SPRING, MARYLAND 20902
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY
20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Andrew J. Cole
22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Obstructive lung disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Rheumatoid Arthritis
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Exposure to Toluene Diisocyanate
24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: 024571
29d. DATE SIGNED (Month, Day, Year): ▶ 9/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jay Weiner 4701 Randolph Rd Rockville, Md 20852
31. DATE FILED (Month, Day, Year): SEP 8 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25917
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELLEN V. KAMMERER | | | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 7 1989 | 3. TIME OF DEATH: 12:00 NOON |
| 4. SOCIAL SECURITY NUMBER: 219-74-7775 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): MARCH 7, 1909 | 8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC |
| 9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSP. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK | | 9c. COUNTY OF DEATH: MONTGOMERY CTY. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 220 BADEN STREET | | 10f. ZIP CODE: 20901 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): JAMES GIORDANO | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY OWENS | |
| 19a. INFORMANT'S NAME (Type/Print): JOSEPH KAMMERER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9413 LAKESIDE DRIVE, VIENNA, VIRGINIA 22182 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN | 20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael F. Bigler | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 2090 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PENDING RESULTS OF AUTOPSY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL INSUFFICIENCY

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Arnold G. Levy MD | 29c. LICENSE NUMBER: D15790 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-8-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARNOLD G. LEVY, M.D. 1106 SPRING ST., SILVER SPRING, MD. 20910 | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albert Herman Krueger
2. DATE OF DEATH: MONTH 9 DAY 6 YEAR 89
3. TIME OF DEATH: 5:55 PM
4. SOCIAL SECURITY NUMBER: 319-05-8590
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 16, 1902
8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): Wilson Health Care Center
9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg
9c. COUNTY OF DEATH: Montgomery

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1205 Galena Road
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrator
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): Herman Krueger
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary (Schoh) Krueger
19a. INFORMANT'S NAME (Type/Print): Mary Louise Jones
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1205 Galena Road Rockville, Maryland 20852
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
20c. LOCATION — City or Town, State: Silver Spring, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, Maryland 20877

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia — 1 Mo
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
prostate cancer
cerebrovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John R. Melnick MD
29c. LICENSE NUMBER: D19294
29d. DATE SIGNED (Month, Day, Year): 9/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN R. MELNICK 911 Russell Ave. Gaithersburg, MD. 20879
31. DATE FILED (Month, Day, Year): SEP 7 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marion S. King | | 2. DATE OF DEATH (Month, Day, Year): Sept. 2 1989 | 3. TIME OF DEATH: 10 : 30 p M |
| 4. SOCIAL SECURITY NUMBER: 578-62-5703 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 28, 1899 |
| 8. BIRTHPLACE (State or Foreign Country): IL | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Carriage Hill-Bethesda | 9b. CITY, TOWN OR LOCATION OF DEATH: Beth. | 9c. COUNTY OF DEATH: Momtgomery | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Bethesda | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5215 West Cedar Lane | 10f. ZIP CODE: 20814 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Music Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): Louis Spencer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose(Unknown) | | |
| 19a. INFORMANT'S NAME (Type/Print): Marion K. Kelly | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7301 Millwood Rd. Bethesda, MD | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory | 20c. LOCATION — City or Town, State: Alex., VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brad L. Wiesbrenner | 22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-pulmonary arrest. DUE TO (OR AS A CONSEQUENCE OF): | terminal |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic brain syndrome, suspected Alzheimer's disease DUE TO (OR AS A CONSEQUENCE OF): | 7+ years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic heart disease with complete heart block.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Richard M. Huffman MD | 29c. LICENSE NUMBER: DC 2660 | 29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 3, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard M. Huffman 3301 NM Ave. NW Wash., DC 20016

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 5 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 25920

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN F. KANE | | | 2. DATE OF DEATH: MONTH SEPT. DAY 4, YEAR 1989 | 3. TIME OF DEATH: 7:35 A M |
| 4. SOCIAL SECURITY NUMBER: 199-16-4239 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 27, 1927 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): 5 BURKET COURT | | 9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING | | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5 BURKET COURT | | 10f. ZIP CODE: 20910 | 10g. CITIZEN OF WHAT COUNTRY: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1946 to 1966 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 8+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DIRECTOR OF SAFETY | 16b. KIND OF BUSINESS/INDUSTRY: GEORGETOWN UNIVERSITY |
| 17. FATHER'S NAME (First, Middle, Last): FREDERICK KANE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE MCCLELLAN | |
| 19a. INFORMANT'S NAME (Type/Print): JANICE C. KANE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 BURKET COURT, SILVER SPRING, MARYLAND 20910 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY | 20c. LOCATION — City or Town, State: ARLINGTON, VIRGINIA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael L. Bigler | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardio respiratory arrest | immediate |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Metastatic gastric adeno carcinoma | 4 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William V. Walsh MD | 29c. LICENSE NUMBER: D 36669 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5 Sept 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
WILLIAM V. WALSH, M.D. WALTER REED ARMY MEDICAL CENTER, WASHINGTON, D.C. 20307

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALMA ILZE KRASTS
2. DATE OF DEATH (Month, Day, Year): Sept. 2, 89
3. TIME OF DEATH: 752 M
4. SOCIAL SECURITY NUMBER: 214-30-0908
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): APRIL 30, 1897
8. BIRTHPLACE (State or Foreign Country): LATVIA
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: KENSINGTON
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 2909 BURTON HILL DRIVE
10f. ZIP CODE: 20895
10g. CITIZEN OF WHAT COUNTRY? LATVIA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): UNKNOWN BLUMS
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN
19a. INFORMANT'S NAME (Type/Print): ILMARS FRIZIS KRASTS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2911 BURTON HILL DRIVE, KENSINGTON, MARYLAND 20895
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ROCK CREEK CEMETERY
20c. LOCATION — City or Town, State: WASHINGTON, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael L. Bigler
22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial Dis.
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic Myocardial Dis. yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined.
28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John S. Rogers, MD
29c. LICENSE NUMBER: D0997?
29d. DATE SIGNED (Month, Day, Year): Sept. 7, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): JOHN S. ROGERS, MD 1919 SEMINARY ROAD, SILVER SPRING, MARYLAND 20910
31. DATE FILED (Month, Day, Year): SEP 8 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25922

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert T. Key | | | 2. DATE OF DEATH (Month, Day, Year): September 7, 1989 | 3. TIME OF DEATH: 9:35 A M |
| 4. SOCIAL SECURITY NUMBER: 127-28-2930 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 20, 1937 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): 6305 Rockhurst Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Bethesda | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6305 Rockhurst Road | | 10f. ZIP CODE: 20817 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1954-1958 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Marketing Consultant | 16b. KIND OF BUSINESS/INDUSTRY: Self-employed |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John Key | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Morris |
| 19a. INFORMANT'S NAME (Type/Print): Mireille L. Key | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6305 Rockhurst Road, Bethesda, MD 20817 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory | 20c. LOCATION — City or Town, State: Silver Spring, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp | 22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Kaposi's Sarcoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acquired Immunodeficiency Syndrome | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Kenneth Milk MD | 29c. LICENSE NUMBER: D33686 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Milk, MD 18111 Prince Philip Dr. Olney, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH A. KIRBY / Elizabeth A. Kirby | | | 2. DATE OF DEATH Month: 9 Day: 4 Year: 89 | 3. TIME OF DEATH 12 05 PM |
| 4. SOCIAL SECURITY NUMBER 104-16-2178 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year) Sept 26,1922 | 8. BIRTHPLACE (State or Foreign Country) New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | | 9c. COUNTY OF DEATH Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE California | 10b. COUNTY Monterey | 10c. CITY, TOWN OR LOCATION Carmel | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER P. O. Box 3868 | | 10f. ZIP CODE 93921 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES World War II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Budget Analyst | 16b. KIND OF BUSINESS/INDUSTRY U. S. Government |
| 17. FATHER'S NAME (First, Middle, Last) Francis Kirby | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret B. Hickey | |
| 19a. INFORMANT'S NAME (Type/Print) Vera J. Beck | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 3868, Carmel, CA 93921 | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Crematory | 20c. LOCATION — City or Town, State Alexandria, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Michael D Nelson | | 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 Wisconsin Av., Washington, DC 20016 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pulmonary Embolism — hours
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Breast Carcinoma — 6 years
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) N/A

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kathryn S. Kirwin MD | 29c. LICENSE NUMBER D26992 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KATHRYN S. Kirwin MD 10400 Conn. Ave #606, Kensington MD 20895

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) SEP 08 '89 | 32. REGISTRAR'S SIGNATURE Lisa Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Cleared by Dr Devore

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Desima Lampos | | | 2. DATE OF DEATH (Month, Day, Year): Sept 1, 1989 | 3. TIME OF DEATH: 6:47 P M |
| 4. SOCIAL SECURITY NUMBER: 056-32-8329 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01/12/12 | 8. BIRTHPLACE (State or Foreign Country): GREECE |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spring | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3918 Ilford Road | | 10f. ZIP CODE: 20906 | 10g. CITIZEN OF WHAT COUNTRY? GREECE |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): NICHOLAS CHACONAS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GEORGIA DOUNIAS |
| 19a. INFORMANT'S NAME (Type/Print): CONNIE NICHOLS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3918 ILLFORD ROAD SILVER SPRING, MARYLAND 20906 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMSTERY | 20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial infarction | 45 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive heart disease | 5 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. | 29c. LICENSE NUMBER: D 08805 | 29d. DATE SIGNED (Month, Day, Year): ▶ September 2, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4501 Connecticut Ave., N.W., Washington, D.C. 20008

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Vernon S Laramie — Vernon S. Laramie | | | 2. DATE OF DEATH: MONTH 9 DAY 7 YEAR 89 | 3. TIME OF DEATH: 240 AM |
| 4. SOCIAL SECURITY NUMBER: 498-03-6997 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-12-20 | 8. BIRTHPLACE (State or Foreign Country): Missouri |
| 9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Potomac | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10318 Democracy Lane | | 10f. ZIP CODE: 20854 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Manager | 16b. KIND OF BUSINESS/INDUSTRY: N. C. R. | |
| 17. FATHER'S NAME (First, Middle, Last): Will Laramie | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Benoist | |
| 19a. INFORMANT'S NAME (Type/Print): Betty Jane Laramie | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10318 Democracy Lane, Potomac, MD 20854 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Gabriel's Cemetery | 20c. LOCATION — City or Town, State: Potomac, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eileen W. Rapp | | 22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Renal Carcinoma, metastatic | 3 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Duodenal Ulcer with hemmorhage

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Lee R. Pennington, M.D. | 29c. LICENSE NUMBER: D21115 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/7/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lee R. Pennington, M.D. 11500 Old Georgetown Rd., Rockville, Md. 20852 | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marion B. Mayers | | | 2. DATE OF DEATH (Month, Day, Year): September 9, 1989 | 3. TIME OF DEATH: 7:30 P M |
| 4. SOCIAL SECURITY NUMBER: 298-28-6874 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 17, 1934 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): 10008 Weatherwood Court | | 9b. CITY, TOWN OR LOCATION OF DEATH: Potomac | | 9c. COUNTY OF DEATH: Montgomery |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Potomac | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10008 Weatherwood Court | | 10f. ZIP CODE: 20854 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Manager | | 16b. KIND OF BUSINESS/INDUSTRY: Real Estate |
| 17. FATHER'S NAME (First, Middle, Last): George S. Botsford | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lois G. Ferguson | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert G. Mayers | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10008 Weatherwood Court, Potomac, MD 20854 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory | | 20c. LOCATION — City or Town, State: Silver Spring, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter F. Govatos | | 22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Breast Cancer | 3 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John E. Yerg MD | 29c. LICENSE NUMBER: D 33554 | 29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 9, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John E. Yerg, M. D., 5401 Western Ave., NW, Washington, DC 20015

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25927

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): STANLEY A. MATE | | | 2. DATE OF DEATH (Month, Day, Year): 9 8 89 | 3. TIME OF DEATH: 5P M |
| 4. SOCIAL SECURITY NUMBER: 413-03-2454 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Apr. 20, 1914 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spring | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 13007 Broadmore Road | | 10f. ZIP CODE: 20904 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW11 | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): 4 yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired): Budget and Consultant Finance | 16b. KIND OF BUSINESS/INDUSTRY: National Rifle Association | |
| 17. FATHER'S NAME (First, Middle, Last): (unknown) Mate | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): (unknown) Butler | |
| 19a. INFORMANT'S NAME (Type/Print): Lia Mate | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13007 Broadmore Road, Silver Spring, Md. 20904 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from state 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Quantico National Cemetery | 20c. LOCATION — City or Town, State: Quantico, VA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lung Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Philip Schwartz MD | 29c. LICENSE NUMBER: MD 024398 | 29d. DATE SIGNED (Month, Day, Year): 9 9 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 15225 Shady Grove Rd #206 Rockville, MD 20850 | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HISANO MIGAKI
2. DATE OF DEATH: Month 9 Day 6 Year 89
3. TIME OF DEATH: 2:00 p M
4. SOCIAL SECURITY NUMBER: 532-48-3015
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/05/97
8. BIRTHPLACE (State or Foreign Country): JAPAN
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: GAITHERSBURG
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 14800 SOFT WIND DR
10f. ZIP CODE: 20878
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): UNKNOWN EMOTO
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN

19a. INFORMANT'S NAME (Type/Print): GEORGE MIGAKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14800 SOFTWIND DRIVE, GAITHERSBURG, MARYLAND 20878

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREENWOOD CEMETERY
20c. LOCATION — City or Town, State: SPOKANE, WASHINGTON

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. AZOTEMIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ACUTE RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Edward Richards MD
29c. LICENSE NUMBER: D-12703
29d. DATE SIGNED (Month, Day, Year): 9-7-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDWARD RICHARDS M.D. 10301 GEORGIA AVENUE, SILVER SPRING, MARYLAND 20902
31. DATE FILED (Month, Day, Year): SEP 8 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

DHMH-16 Rev 1/89

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89 25929

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MADELINE ANN MANANSALA

**2. DATE OF DEATH** (Month, Day, Year): SEP 16 1989

**3. TIME OF DEATH**: 12:58 A M

**4. SOCIAL SECURITY NUMBER**: N/A

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS 2, MIN. 24

**7. DATE OF BIRTH** (Month, Day, Year): SEP 15 1989

**8. BIRTHPLACE** (State or Foreign Country): MARYLAND

**9a. FACILITY NAME** (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BETHESDA

**9c. COUNTY OF DEATH**: MONTGOMERY

**RESIDENCE OF DECEDENT**

**10a. STATE**: DISTRICT OF COLUMBIA

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**:

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 4201 MASSACHUSETTS AVENUE, NW

**10f. ZIP CODE**: 20001

**10g. CITIZEN OF WHAT COUNTRY?**: UNITED STATES

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): N/A

**16b. KIND OF BUSINESS/INDUSTRY**: N/A

**17. FATHER'S NAME** (First, Middle, Last): EDGARDO MANANSALA

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): JESSICA KING

**19a. INFORMANT'S NAME** (Type/Print): JESSICA KING MANANSALA

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4201 MASSACHUSETTS AVE.,NW, #8029,WASHINGTON,DC 20001

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): HOSPITAL

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): NATIONAL NAVAL MEDICAL CENTER

**20c. LOCATION — City or Town, State**: BETHESDA, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶

**22. NAME AND ADDRESS OF FACILITY**:

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE** (Final disease or condition resulting in death) →
a. EXTREME PREMATURITY (460 GRAMS)
DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☒ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☒ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**25. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] M.D.

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year) ▶ 19 Sept 89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): DAVID L,MECKLER, LT, MC, USNR
NATIONAL NAVAL MEDICAL CENTER
BETHESDA, MD 20814-5011

**31. DATE FILED** (Month, Day, Year): SEP 25 1989

**32. REGISTRAR'S SIGNATURE**: [signature]

DHMH-16 Rev 1/89

89 25930

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DONALD H. McHARGUE | | 2. DATE OF DEATH (Month / Day / Year): 8 / 30 / 89 | 3. TIME OF DEATH: 1148 A M |
| 4. SOCIAL SECURITY NUMBER: 579-40-4174 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4/3/31 — 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | 9c. COUNTY OF DEATH: Montgomery |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 10310 INSLEY STREET | | 10f. ZIP CODE: 20902 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: KOREA | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TECHNICIAN | 16b. KIND OF BUSINESS/INDUSTRY: A T & T | |
| 17. FATHER'S NAME (First, Middle, Last): ORVILLE WALTER McHARGUE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELSIE RAY | |
| 19a. INFORMANT'S NAME (Type/Print): ROSEMARIE McHARGUE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10310 INSLEY STREET, SILVER SPRING, MARYLAND 20902 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN | 20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Embolus — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Venous thrombosis — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 X NO | HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Edward Richards M.D. | D12703 | 9-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDWARD J.RICHARDS 10301 GEORGIA AVE., SILVER SPRING, MARYLAND 20902

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 6 89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RICKY NMN MORRIS | | | | 2. DATE OF DEATH (Month, Day, Year): 09 02 1989 | 3. TIME OF DEATH: 9:35 A M |
| 4. SOCIAL SECURITY NUMBER: 252 21 6465 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 28 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 01 09 61 | 8. BIRTHPLACE (State or Foreign Country): GEORGIA |
| 9a. FACILITY NAME (If not institution, give street and number): NAVAL MEDICAL CENTER 8901 NATIONAL WISCONSIN | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: GEORGIA | 10b. COUNTY: GLYNN | 10c. CITY, TOWN OR LOCATION: BRUNSWICK | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 904 BARTON ST | | 10f. ZIP CODE: 31520 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1979-84 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ACCOUNTANT | 16b. KIND OF BUSINESS/INDUSTRY: COX ENTERPRISE INC |
| 17. FATHER'S NAME (First, Middle, Last): MALACHI NMN MORRIS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BETTY JEAN BREWTON | |
| 19a. INFORMANT'S NAME (Type/Print): BETTY MORRIS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 904 BARTON ST. BRUNSWICK, GA 31520 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREENWOOD CEMETERY | 20c. LOCATION — City or Town, State: BRUNSWICK,GA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W.S. Jeffers | | 22. NAME AND ADDRESS OF FACILITY: 389 R.I. AvenueN.W. Frazier's Funeral Home Washington,D.C. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYCOSIS FUNGOIDES | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEDUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEDUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATIDN (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C.A. Thompson LT MC USN | 29c. LICENSE NUMBER: 036734 MD | 29d. DATE SIGNED (Month, Day, Year): ▶ 09 03 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print): C.A. THOMPSON, LT MC USNR | NATIONAL NAVAL MEDICAL CENTER BETHESDA MARYLAND 20814 | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GERTRUDE P. MCKAIG | | | | 2. DATE OF DEATH (Month, Day, Year): SEPT 03 1989 | 3. TIME OF DEATH: 7:05A M |
| 4. SOCIAL SECURITY NUMBER: 155-36-2518 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): MARCH 21, 1902 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY | | 9c. COUNTY OF DEATH: MONTG. |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3501 SOUTH LEISURE WORLD BOULEVARD | | 10f. ZIP CODE: 20906 | 10g. CITIZEN OF WHAT COUNTRY: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER |
| 16b. KIND OF BUSINESS/INDUSTRY: | | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): JACOB WOLFE PIERSOL | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA D. LUCE |
| 19a. INFORMANT'S NAME (Type/Print): J. ARTHUR McKAIG | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3501 SO. LEISURE WORLD BLVD, SILVER SPRING, MD 20906 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN | 20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven J. Collins | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. OVERWHELMING SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):

c. END STAGE PARKINSON'S DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: VERTEBRAL BODY COMPRESSION FRACTURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year): SEPTEMBER 3, 1989 | 28b. TIME OF INJURY: 6:45 A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY (At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jonathan Plotsky MD | 29c. LICENSE NUMBER: D39589 | 29d. DATE SIGNED (Month, Day, Year): ▶ September 3, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathan Plotsky 12102 Georgia Ave Wheaton, Maryland | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO-THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George Otto March | | | 2. DATE OF DEATH (Month / Day / Year): 8 / 26 / 89 | 3. TIME OF DEATH: 3:45 P M |
| 4. SOCIAL SECURITY NUMBER: 129-28-0152 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 54 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12-5-34 | 8. BIRTHPLACE (State or Foreign Country): WEST GERMANY |
| 9a. FACILITY NAME (If not institution, give street and number): Potomac River 1/2 ml. S. of Anlers' | | 9b. CITY, TOWN OR LOCATION OF DEATH: NONE | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: NEW YORK | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: PALISADES | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: ~~ROUTE 9 WEST~~ ROUTE 1, BOX 260 | | 10f. ZIP CODE: 10964 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LIMO SERVICE/ESTATE MGMT | 16b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOYED |
| 17. FATHER'S NAME (First, Middle, Last): WALTER F MARCH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE GOPFERT | |
| 19a. INFORMANT'S NAME (Type/Print): PRITA M SHORTT | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10712 POHICK ROAD, FAIRFAX STATION, VA 22039 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NORTHERN VIRGINIA CREMATORY | 20c. LOCATION — City or Town, State: ARLINGTON, VIRGINIA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marshall W Rahn | | 22. NAME AND ADDRESS OF FACILITY: DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA 22314 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Drowning

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [X] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): FOUND: 8-26-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject drowned |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND: IN RIVER | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): FOUND: Potomac River, ½ mi. S. of Anlers', Montgomery Co., Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 8-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn Street Baltimore, Md. 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 - 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25934

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Meeks Norma May. Meeks. | | 2. DATE OF DEATH (Month, Day, Year): 9 - 6 - 89 | 3. TIME OF DEATH: 5-50P M |
| 4. SOCIAL SECURITY NUMBER: 302 03 5069 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 25 1898 |
| 8. BIRTHPLACE (State or Foreign Country): Kentucky | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Heritage Nursing Home. | 9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park, | 9c. COUNTY OF DEATH: Montgomery. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland. | 10b. COUNTY: Montgomery. | 10c. CITY, TOWN OR LOCATION: Takoma Park, | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7515 Carroll Ave. | 10f. ZIP CODE: 20912 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White. |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unavailable; College (1-4 or 5+): Unavailable | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: At Home | |
| 17. FATHER'S NAME (First, Middle, Last): (Unavailable) Meadows | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie (Unavailable) | | |
| 19a. INFORMANT'S NAME (Type/Print): Harold W. Meeks. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7515 Carroll Ave. Takoma Park, Montg. Co, Md. 20912 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln | 20c. LOCATION — City or Town, State: Bladensburg Md. Brentwood. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William T. Conrad | 22. NAME AND ADDRESS OF FACILITY: Takoma Funeral Home. 254 Carroll St. N. W. D. C. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Pulmonary Arrest. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery disease. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Pneumonia | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Centrovascular accident c hemiplegia.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D | 29c. LICENSE NUMBER: D17843 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/7/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Vivek C VAID M.D 3311 Toledo Terrace Rockville Md

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell |

DHMH-18 Rev 1/89

89 25935

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Richard Francis Norris | | | | | 2. DATE OF DEATH (Month, Day, Year): September 8, 1989 | | 3. TIME OF DEATH: 8:30 A.M |
| 4. SOCIAL SECURITY NUMBER: 284-14-7148 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 2, 1923 | | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): 5012 Aspen Hill Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | | | 9c. COUNTY OF DEATH: Montgomery | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | | 10c. CITY, TOWN OR LOCATION: Rockville | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 5012 Aspen Hill Road | | | 10f. ZIP CODE: 20853 | | | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II and Korea | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrical Engineer | | | 16b. KIND OF BUSINESS/INDUSTRY: Private Contractor | |
| 17. FATHER'S NAME (First, Middle, Last): Francis Norris | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Shivley | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Lee Norris | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5012 Aspen Hill Road, Rockville, Maryland 20853 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | | | 20c. LOCATION — City or Town, State: Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ David E. Perry M00803 | | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Dysrhythmia / Sudden Death

DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Prostate Malignancy

DUE TO (OR AS A CONSEQUENCE OF): d. Hypercholesterolemia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Arthritis
Hypertension

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Douglas R. Shumaker, MD | D27301 | ▶ September 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Douglas R. Shumaker, M.D. 615 West Montgomery Avenue Rockville, MD. 20850

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Margaret Kelly / Lucy / Niess | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 10, 1989 | 3. TIME OF DEATH: 5 am M |
| 4. SOCIAL SECURITY NUMBER: 578-66-8244 | 5. SEX: 1 ☐ M 2 ☒ F | 5. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 15, 1898 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): 5200 Falmouth Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | | 9c. COUNTY OF DEATH: Mont. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Bethesda | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5200Falmouth Rd. | | 10f. ZIP CODE: 20816 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant | 16b. KIND OF BUSINESS/INDUSTRY: Navy Dept. | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Payne Kelly | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Sowers | |
| 19a. INFORMANT'S NAME (Type/Print): Dianne Irving | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5108 Randall Lane Beth., MD | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Warrenton Cem. | 20c. LOCATION — City or Town, State: Warrenton, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael E. Nelson | | 22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Failure to thrive

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined | 25a. DATE OF INJURY (Month, Day, Year) / 25b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| | 25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 25f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. Mustafa, M.D. | 29c. LICENSE NUMBER: 15765O | 29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 11, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mahmoud H. Mustafa, M.D. 2440 M St. NW Wash., DC 20037

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles W. Nelson | | | | 2. DATE OF DEATH (Month, Day, Year): AUG. 31, 1989 | 3. TIME OF DEATH: 3:30 P M |
| 4. SOCIAL SECURITY NUMBER: 027-10-4566 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 95 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JUNE 8, 1894 | 8. BIRTHPLACE (State or Foreign Country): MASSACHUSETT |
| 9a. FACILITY NAME (If not institution, give street and number): KENSINGTON GARDENS NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: KENSINGTON | | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: GAITHERSBURG | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 101 ODENDHAL AVENUE, APT. 816 | | 10f. ZIP CODE: 20877 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWI | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 YEARS | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN | 16b. KIND OF BUSINESS/INDUSTRY: U.S. ENVELOPE COMPANY |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM H. P. NELSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CORA B. EATON | |
| 19a. INFORMANT'S NAME (Type/Print): BARBARA B. NELSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 ODENDHAL AVENUE, APT. 816, GAITHERSBURG, MARYLAND 20877 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY | 20c. LOCATION — City or Town, State: ALEXANDRIA, VIRGINIA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E Dooley | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | 3/31/89 |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Arteriosclerotic Cardiovascular Disease | Year |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [/] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Witness not coming for Autopsy | D-31918 AF 312 6213 | ▶ 9/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3701 Rossmoor Blvd Silver Spring Md 20906

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 7 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Patricia E. Nicklaw (Patricia E. Nicklaw) | | 2. DATE OF DEATH (Month, Day, Year): 9 - 3 - 89 | 3. TIME OF DEATH: 11:25 PM |
| 4. SOCIAL SECURITY NUMBER: 133-22-9092 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct 7. 1928 |
| 8. BIRTHPLACE (State or Foreign Country): Canada | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | 9c. COUNTY OF DEATH: Montgomery | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Kensington | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 11406 Woodson Ave. | 10f. ZIP CODE: 20895 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Roy H. Still | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marguerite DeCant | | |
| 19a. INFORMANT'S NAME (Type/Print): William J. Nicklaw | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11406 Woodson Av., Kensington, MD 20895 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory | 20c. LOCATION — City or Town, State: Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael C Nelson | 22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 Wisconsin Av., Washington, DC 20016 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ONE cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio Respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardio myo pathy.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John Tauber MD | 29c. LICENSE NUMBER: D 08546 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-3-89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Tauber 8218 Wisconsin ave. Bethesda md. | | |
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Lillie Davidson-Randall | |

DHMH-16 Rev 1/89

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89 25939

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gertrude E. O'Brien | | | 2. DATE OF DEATH (Month, Day, Year): August 30, 1989 | 3. TIME OF DEATH: 8:13 P. M |
| 4. SOCIAL SECURITY NUMBER: 578-62-3166 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 10, 1898 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Chevy Chase Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase | | 9c. COUNTY OF DEATH: Montgomery |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: none | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Washington, D.C. | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4600 Conn. Ave, N.W. | | 10f. ZIP CODE: 20008 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: American |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Reg. Nurse | | 16b. KIND OF BUSINESS/INDUSTRY: Hospital |
| 17. FATHER'S NAME (First, Middle, Last): Thomas H. Offutt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): (unavailable-first name) Conroy | | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas M. O'Brien | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 No. Fairfax Drive Arlington, Virginia 22203 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery | | 20c. LOCATION — City or Town, State: Rockville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. DeVol | | 22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home 2222 Wisc. Ave., N.W. Washington, D.C. 20007 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 1 day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Endometrial Cancer-Metastatic | 10 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cachexia of cancer

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|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M |
| 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Steven F. Osborne MD | 29c. LICENSE NUMBER: Md. D30898 | 29d. DATE SIGNED (Month, Day, Year): August 30, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven Osborne, M.D. 2737 Devonshire Place, N.W. Washington, D.C. 20008 | | |
| 31. DATE FILED (Month, Day, Year): SEP 7 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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DHMH-18 Rev 1/89

89 25940

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): ANNE B. PARSHALL
2. DATE OF DEATH (Month, Day, Year): Sept. 6 1989
3. TIME OF DEATH: 12:15 a. M
4. SOCIAL SECURITY NUMBER: 215-44-8662
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 5 1909
8. BIRTHPLACE (State or Foreign Country): Penna.
9a. FACILITY NAME (If not institution, give street and number): 1101 McNeill Lane
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Takoma Park
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 17 Sherman AVenue
10f. ZIP CODE: 20912
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): Business
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fed. Govt. (Ret.)
16b. KIND OF BUSINESS/INDUSTRY: Leg. Asst. O.M.B.
17. FATHER'S NAME (First, Middle, Last): John Pepas
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marian Pincavage
19a. INFORMANT'S NAME (Type/Print): Marianne P. Tull
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1101 McNeill Lane, Silver Spring MD.20904
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore/Washington Crematory
20c. LOCATION — City or Town, State: Laurel, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William T. Conrad
22. NAME AND ADDRESS OF FACILITY: TAKOMA FUNERAL HOME, INC. 254 Carroll St. N. W. Washington DC

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myelofibrosis and pancytopenia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: JOHN REDMOND III M.D. HEMATOLOGY-ONCOLOGY
29c. LICENSE NUMBER: 551-64-6731
29d. DATE SIGNED (Month, Day, Year): ▶ 6 Sept 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): SEP 8 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH-16 Rev 1/89

89 25941

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAMIE V. QUARLES | | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 2 / 89 | 3. TIME OF DEATH: 5:20 AM |
| 4. SOCIAL SECURITY NUMBER: 223-03-5795 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/6/1908 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE | | 9c. COUNTY OF DEATH: MONTGOMERY CO. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: VIRGINIA | 10b. COUNTY: LOUDOUN CO. | 10c. CITY, TOWN OR LOCATION: LEESBURG | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 125 B CLUB HOUSE DR.,S.W. | | 10f. ZIP CODE: 22075 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR | 16b. KIND OF BUSINESS/INDUSTRY: C.& P. TELEPHONE CO. | |
| 17. FATHER'S NAME (First, Middle, Last): MARION S. JACKSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE M. GREEN | |
| 19a. INFORMANT'S NAME (Type/Print): REV.DR.REICHARD | | 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701-VEIRS DR.,ROCKVILLE,MD. 20850 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RIVERVIEW CEMETERY | 20c. LOCATION — City or Town, State: RICHMOND,VA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William M. Hysong | | 22. NAME AND ADDRESS OF FACILITY: THE HYSONG CO.,INC. 1300-N STREET,N.W. WASH.,DC | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute CVA — Acute

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas F. Dooley MD | 29c. LICENSE NUMBER: D16458 | 29d. DATE SIGNED (Month, Day, Year): Sept 2, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas F. Dooley MD, 1904 Georgia Avenue, Olney Md 20832 | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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89 25942

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Maude Violet Raulin | | | | 2. DATE OF DEATH (Month, Day, Year): 08 - 28 - 89 | 3. TIME OF DEATH: 0110 M |
| 4. SOCIAL SECURITY NUMBER: 579-38-5309 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-15-1906 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park | | 9c. COUNTY OF DEATH: Montgomery |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Cottage City | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Cottage City Tower S. #513 | | 10f. ZIP CODE: 20722 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): -------- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Baker | | 16b. KIND OF BUSINESS/INDUSTRY: Bakery | |
| 17. FATHER'S NAME (First, Middle, Last): Ernest Franke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Kellerman | |
| 19a. INFORMANT'S NAME (Type/Print): William Raulin /son/ | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3173 Castleleigh Road, Silver Spring, Md. 20904 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Washington National Cemetery | | 20c. LOCATION — City or Town, State: Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy L. Brohawn | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Myelofibrosis | yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | Congestive Heart Failure | yrs |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D | D 28920 | 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURINDER SINGH 9700 Berwyn House Rd. Suite 10, College Park, MD 20740

31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM J. ROWAN | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 1 / 89 | 3. TIME OF DEATH: 848 A M |
| 4. SOCIAL SECURITY NUMBER: 215-38-2733 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JUNE 16,1907 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | 9c. COUNTY OF DEATH: Mont. | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: CHEVY CHASE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 3704 UNDERWOOD STREET | | 10f. ZIP CODE: 20015 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5 + | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LAWYER | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM J. ROWAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE S. McCAHILL | | |
| 19a. INFORMANT'S NAME (Type/Print): MARGARET M. ROWAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3704 UNDERWOOD STREET CHEVY CHASE,MARYLAND 20015 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY | 20c. LOCATION — City or Town, State: SILVER SPRING,MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Benjamin M Mackey | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W. SIL.SPR.,MD.20901 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

corpulmonale
chronic obstructive pulmonary disease
atrial fibrillation with systemic embolism

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Michael A Lincoln MD | D29293 | 9/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael A. LINCOLN, MD 10313 Georgia Ave Silver Spring Md. 20902

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 6'89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25944

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Caleb Rakov
2. DATE OF DEATH (Month, Day, Year): 9 8 89
3. TIME OF DEATH: 1232 P M
4. SOCIAL SECURITY NUMBER: 060-07-7167
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): Dec. 22, 1901
8. BIRTHPLACE (State or Foreign Country): Russia
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6105 Montrose Road
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES IF YES, GIVE WAR OR DATES: WWI
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 3
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chief Administrative Officer
16b. KIND OF BUSINESS/INDUSTRY: State Liquor Authority New York State
17. FATHER'S NAME (First, Middle, Last): Harris Rakov
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Friedman
19a. INFORMANT'S NAME (Type/Print): Mrs. Harriet Novins (Dtr)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2111 Jefferson Davis Hwy. #1122 Arl., Va 22202
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory
20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary M. Gue
22. NAME AND ADDRESS OF FACILITY: Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary arrest & Resuscitation | sudden |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Acute Aspiration Pneumonia. | sudden |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Dementia Alzheimers Type. | old. |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Loreto S. Albiol, MD
29c. LICENSE NUMBER: D31319
29d. DATE SIGNED (Month, Day, Year): 9-8-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LORETO S. ALBIOL, MD 8218 Wisconsin Ave. Bethesda, MD.
31. DATE FILED (Month, Day, Year): SEP 11 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BEATRICE LUCILE ROBB | | | 2. DATE OF DEATH (Month, Day, Year): September 9, 1989 | 3. TIME OF DEATH: 9:45 a.m. M |
| 4. SOCIAL SECURITY NUMBER: 220-12-4050 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): August 20, 1907 | 8. BIRTHPLACE (State or Foreign Country): Washington, DC |
| 9a. FACILITY NAME (If not institution, give street and number): Wilson Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg | | 9c. COUNTY OF DEATH: Montgomery |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Gaithersburg | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Wilson Health Care Center, 301 Russell Avenue | | 10f. ZIP CODE: 20879 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): ------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Chamber of Commerce | | |
| 17. FATHER'S NAME (First, Middle, Last): Silas Edgar Robb | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances M. Wagoner | | |
| 19a. INFORMANT'S NAME (Type/Print): Theodore Robb (Brother) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4703 Banner Street, Hyattsville, Md. 20781 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | 20c. LOCATION — City or Town, State: Brentwood, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A Bohanan | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Coronary artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John F. Tauber MD | 29c. LICENSE NUMBER: D08546 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-11-89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John F. Tauber, M.D. 8218 Wisconsin Avenue, #414 Bethesda, Maryland 20814 | | |
| 31. DATE FILED (Month, Day, Year): SEP 15 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Hodgson, Olga Robb | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 10 / 1989 | 3. TIME OF DEATH: 6 a M |
| 4. SOCIAL SECURITY NUMBER: 577-08-8043 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5 7 19 | 8. BIRTHPLACE (State or Foreign Country): Nicaragua |
| 9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park, Md. | | 9c. COUNTY OF DEATH: Montgomery Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery County | 10c. CITY, TOWN OR LOCATION: Takoma Park | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6731 New Hampshire Avenue | | 10f. ZIP CODE: 20912 | 10g. CITIZEN OF WHAT COUNTRY? |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Hispanic |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 9th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: None | |
| 17. FATHER'S NAME (First, Middle, Last): Herbert Robb | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Carter | |
| 19a. INFORMANT'S NAME (Type/Print): Olga Rosa Hodgson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6731 New Hampshire Ave.,Takoma Park, Md.20912 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): National Cemetery | 20c. LOCATION — City or Town, State: Bluefield, Nicaragua | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E. Williams | | 22. NAME AND ADDRESS OF FACILITY: Vann & Williams 4804 Ga. Ave.,N.W.,Wash.,D.C. 20011 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CORONARY ARTERY DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. INSULIN DEPENDENT DIABETES | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CHRONIC RENAL FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CEREBRAL INFARCT | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D 19931 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. SUDHAKAR, MD. 7610 CARROLL AVE #230, TAKOMA PARK MD 20912 | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

(4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25947
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

10

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): VIRGIL C. RAUTSAW
2. DATE OF DEATH (Month, Day, Year): 9 - 4 - 89
3. TIME OF DEATH: 1235 M
4. SOCIAL SECURITY NUMBER: 216-46-9215
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 89 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1900
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): SUBURBAN Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda, MD
9c. COUNTY OF DEATH: Montgomery

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Bethesda
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4998 Battery Lane #212
10f. ZIP CODE: 20814
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [✓] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW 1
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12 — College (1-4 or 5+): College
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Police Department
16b. KIND OF BUSINESS/INDUSTRY: D.C. Govt.,
17. FATHER'S NAME (First, Middle, Last): William Rautsaw
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae (unobtainable)
19a. INFORMANT'S NAME (Type/Print): Rose W. Blackburn
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5306 Roosevelt St. Bethesda, Md. 20814
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery
20c. LOCATION — City or Town, State: Suitland, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clark E Wisor
22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home, 11800 N.H. Ave., Silver Spring, Md.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardio Respiratory Arrest | hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Acute Bronchial Pneumonia | 8 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Aspiration Pneumonia | 8 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | Intestinal Obstruction | 10 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure
Chronic Renal Failure
Adrenal Cortical Insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William H Killay MD
29c. LICENSE NUMBER: D0584
29d. DATE SIGNED (Month, Day, Year): 9-5-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William H. Killay, MD 8218 Wisc. Ave., Bethesda, Md. 20814
31. DATE FILED (Month, Day, Year): SEP 7 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIA BOHRER ROZSA | | | 2. DATE OF DEATH (Month, Day, Year): 08 30 89 | 3. TIME OF DEATH: 8:20 AM |
| 4. SOCIAL SECURITY NUMBER: 579 46 1581A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07/26/15 | 8. BIRTHPLACE (State or Foreign Country): Germany |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | | 9c. COUNTY OF DEATH: Mont. |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY: Mont. | 10c. CITY, TOWN OR LOCATION: Silver Spring | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2601 Glenalley Ave. | | 10f. ZIP CODE: 20906 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | | 16b. KIND OF BUSINESS/INDUSTRY: Giant Food Store |
| 17. FATHER'S NAME (First, Middle, Last): Sebastian Bohrer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Krenzenz U/A | | |
| 19a. INFORMANT'S NAME (Type/Print): Julian Rocha | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1503 Brigadoon Dr., Clearwater, Fla. 34619 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State: Brentwood Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James [illegible] | | 22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home 2222 Wisc. Ave., N.W., Wash. D.C. 20007 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cerebrovascular accident | <1 HR. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Louis Kozloff MD | D23190 | ▶ 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LOUIS KOZLOFF, MD 8218 WISC. AVE; BETHESDA, MD. 20814

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 7 '89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Doris C Singleton | | 2. DATE OF DEATH (Month, Day, Year): 9 4 1989 | 3. TIME OF DEATH: 11 30 P M |
| 4. SOCIAL SECURITY NUMBER: 228-72-1082 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 43 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4/2/46 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Tokoma Park | 9c. COUNTY OF DEATH: Montgomery | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Hyattsville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 814 Sheridan Street | | 10f. ZIP CODE: 20783 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk Typist | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Sharp | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Martin Sharp | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 785, Warrenton, VA 22186 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WARRENTON CEMETERY | 20c. LOCATION — City or Town, State: Warrenton, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George C. Joynes | 22. NAME AND ADDRESS OF FACILITY: JOYNES FUNERAL HOME, INC. 35 N. 3rd. St., Warrenton, Virginia | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Failure | 8 wks |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Malignant pleural Effusions | 16 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Metastatic Breast Cancer | 14 months |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Thos A Benninger MD | | 29c. LICENSE NUMBER: D08754 | 29d. DATE SIGNED (Month, Day, Year): 9/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas A. Benninger MD 7525 Greenway Ctr. Dr. Greenbelt MD 20770 | | | |
| 31. DATE FILED (Month, Day, Year): Sept. 26 1989 | Jurisdiction responsible | | |

DHMH-18 Rev 1/89

89 25950

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ETHEL H SEMLER | | | | 2. DATE OF DEATH (Month, Day, Year): 9 01 89 | 3. TIME OF DEATH: 7 27 PM |
| 4. SOCIAL SECURITY NUMBER: 077-07-3632 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 95 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): DEC. 12, 1893 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: NEW YORK | 10b. COUNTY: NASSAU | 10c. CITY TOWN OR LOCATION: OCEANSIDE, LONG ISLAND | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2900 ROCKAWAY AVENUE | | 10f. ZIP CODE: 11572 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ACCOUNTANT | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): ARTHUR E. MOORE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE EATON | |
| 19a. INFORMANT'S NAME (Type/Print): MARIAN S. SAFFORD | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12800 CAMELLIA DRIVE SILVER SPRING, MARYLAND 20906 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. JOHNS-METHODIST CEMETERY | 20c. LOCATION — City or Town, State: ELMONT, NEW YORK |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION | minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC CARDIOVASCULAR DIS | 4 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Deputy Medical Examiner | DO 1852 | ▶ 9-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL A DEVOE MD 4203 Queensbury Road HYATTSVILLE MD 20781

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 6 '89 | Julia Davidson-Randell |

6

DHMH-16 Rev 1/89

89 25951

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian E. Springirth | | 2. DATE OF DEATH: MONTH 9 DAY 5 YEAR 89 | 3. TIME OF DEATH: 9 40 M |
| 4. SOCIAL SECURITY NUMBER: 214-34-6662 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/18/03 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | 9c. COUNTY OF DEATH: Montgomery | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Kensington | 10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3000 Upton Dr. | 10f. ZIP CODE: 20895 | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Phillips | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amanda Collins | |
| 19a. INFORMANT'S NAME (Type/Print): Lawrence A. Springirth | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12536 Timber Hollow Place Germantown, MD. 20874 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park | 20c. LOCATION — City or Town, State: Rockville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George J Kaplan M00335 | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave. Rockville, Maryland 20850 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CEREBRO VASCULAR ACCIDENT | 2 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): b. | CEREBRAL ARTERIOSCLEROSIS | 5 YRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION. CORONARY ARTERY DIS. DIABETES

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Family PHYS | 29c. LICENSE NUMBER: D0 2012 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID GOLDENBERG MD 9801 GEORGIA SILVER SPRING MARYLAND 20902 | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25952

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NO NAME SUBMITTED SPARKS | | | 2. DATE OF DEATH (Month, Day, Year): 9 13 89 | 3. TIME OF DEATH: 1645A M |
| 4. SOCIAL SECURITY NUMBER: None | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS 1, MIN. 24 | 7. DATE OF BIRTH (Month, Day, Year): 9/13/89 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Gaithersburg | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 21600 Glendalough Road | | 10f. ZIP CODE: 20882 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): Stephen Merrick Sparks | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elisabeth Jane Bailey | |
| 19a. INFORMANT'S NAME (Type/Print): Elisabeth B. Sparks | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21600 Glendalough Rd. | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shady Grove Adventist Hospital | 20c. LOCATION — City or Town, State: Rockville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ N/A | | 22. NAME AND ADDRESS OF FACILITY: N/A | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Extreme Prematurity | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robert J. Buczek M.D. | | ▶ 9-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert J. Buczek M.D. 9901 Med. Center Dr.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 25 '89 | Julia Davidson-Randall |

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Item:4 per FH G-656
10-30-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HAZEL VIRGINIA STEINBERG | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 4, 1989 | 3. TIME OF DEATH: 6:45 P M |
| 4. SOCIAL SECURITY NUMBER: ~~284-14-9458~~ 161-05-1082 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): APRIL 21, 1922 | 8. BIRTHPLACE (State or Foreign Country): OKLAHOMA |
| 9a. FACILITY NAME (If not institution, give street and number): 15316 PINE ORCHARD DRIVE #2E | | 9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING | | 9c. COUNTY OF DEATH: MONTGOMERY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 15316 PINE ORCHARD DRIVE #2E | | 10f. ZIP CODE: 20906 | 10g. CITIZEN OF WHAT COUNTRY: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL SILAS HULBERT | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HAZEL NATALA MEADE |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print): HARVEY E. STEINBERG | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15316 PINE ORCHARD DRIVE #2E SILVER SPRING, MD 20906 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY | 20c. LOCATION — City or Town, State: ARLINGTON, VIRGINIA |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James E Dooley | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD. W. SIL. SPR., MD 20901 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatic Failure Secondary to Metastatic Cancer | 2.5 months |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Cerebral Edema Secondary to Metastatic Cancer | 2.5 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. Metastatic Breast CANCER to Liver + Brain | 4 months |
| DUE TO (OR AS A CONSEQUENCE OF): | d. Breast Cancer, T1 N2 Mo | 19 months |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Norman J. Martin, MD. Lt.Col | 29c. LICENSE NUMBER: 125-36-9000 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5 Sept '89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NORMAN J. MARTIN, MD. U.S. Army Staff Oncologist, Walter Reed AMC, Washington D.C.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ~~72~~ hours after death. Page 6 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

B

Norman J. Martin
LTC, MC
125-36-9000

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SU TRAN | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 2 / 89 | 3. TIME OF DEATH: 455 PM |
| 4. SOCIAL SECURITY NUMBER: 220-02-8963 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 41 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): MARCH 15, 1948 | 8. BIRTHPLACE (State or Foreign Country): VIETNAM |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring MD | 9c. COUNTY OF DEATH: Montgomery | | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 503 E. MELBOURNE AVE. | 10f. ZIP CODE: 20901 | 10g. CITIZEN OF WHAT COUNTRY?: VIETNAM | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: ASIAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WELDER | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): LO TRAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): QUYEN NGUYEN | | |
| 19a. INFORMANT'S NAME (Type/Print): KY TRAN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 E. MELBOURNE AVENUE SILVER SPRING, MARYLAND 20901 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NATIONAL MEMORIAL PARK | 20c. LOCATION — City or Town, State: FALLS CHURCH, VIRGINIA | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Oliver D. Bland | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARRYTHMIA - ATRIAL FIBRICATION | 3 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): | 9 hours |
| | c. BRAIN DEATH DUE TO (OR AS A CONSEQUENCE OF): | 8 hours |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: N/A

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 09-02-89 | 28b. TIME OF INJURY: 7:30 AM | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: FAINTED AT DRIVEWAY

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 503 EAST MELBOURNE S. SPRING MARYLAND

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Dang C. Bui MD | D # 26894 | ▶ 9-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANG C. BUI, MD -

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 9-2-89 SEP 6'89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DONALD LEROY TELFER | | | 2. DATE OF DEATH (Month, Day, Year): 09 05 1989 | 3. TIME OF DEATH: 10:50 P.M |
| 4. SOCIAL SECURITY NUMBER: 182-28-8439 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): FEB. 11, 1929 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): 1702 Glenkarney Place | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1702 GLENKARNEY PLACE | | 10f. ZIP CODE: 20902 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: KOREA | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): GAS STATION OWNER | 16b. KIND OF BUSINESS/INDUSTRY: SELF EMPLOYED/GAS STATION | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES TELFER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH A. HART | |
| 19a. INFORMANT'S NAME (Type/Print): NOLA E. TELFER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1702 GLENKARNEY PLACE SILVER SPRING, MD 20902 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOWER TUSCARORA CEMETERY | 20c. LOCATION — City or Town, State: ACADEMIA, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute myocardial disease. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Examiner | | 29c. LICENSE NUMBER: DO 9975 | 29d. DATE SIGNED (Month, Day, Year): 09/06/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John S. Rogers, M.D., 1919 Seminary Road, Silver Spring, Montgomery, MD 20910 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

2541

Item:10g per FH G-658
12-7-89 cm

Item 14;G-663;
5-14-90: dr

89 25956

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Henner Otto Behrend-Janssen Wachs | | | 2. DATE OF DEATH (Month, Day, Year): September 4, 1989 | 3. TIME OF DEATH: 3:00 AM |
| 4. SOCIAL SECURITY NUMBER: 577 92 9798 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 47 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03-04-1942 | 8. BIRTHPLACE (State or Foreign Country): Germany |
| 9a. FACILITY NAME (If not institution, give street and number): 7825 Overhill Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Bethesda | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7825 Overhill Road | | 10f. ZIP CODE: 20814 | 10g. CITIZEN OF WHAT COUNTRY? ~~GERMANY~~ United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc.: White ~~Caucasian~~ |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Banker | 16b. KIND OF BUSINESS/INDUSTRY: International Banking | |
| 17. FATHER'S NAME (First, Middle, Last): Otto Wachs | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaretha Schuchmann | |
| 19a. INFORMANT'S NAME (Type/Print): Marie-Elisabeth Von Ketelhodt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Rögenweg, 2000 Hamburg, Germany 67 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | 20c. LOCATION — City or Town, State: Bethesda, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00689 | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 300 West Montgomery Avenue, Bethesda, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Esophageal Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | DC 16615 | ▶ 9/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Christopher McMackin, M.D. 2112 F Street, N.W., #603, Washington, D.C.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 8 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25957

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Warren H. Wagner | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 5 1989 | 3. TIME OF DEATH: 12:15 A M |
| 4. SOCIAL SECURITY NUMBER: 714-18-7142 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 17, 1919 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): 11304 Hawhill End | | 9b. CITY, TOWN OR LOCATION OF DEATH: Potomac | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Potomac | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 11304 Hawhill End | | 10f. ZIP CODE: 20854 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Intelligence Officer | 16b. KIND OF BUSINESS/INDUSTRY: Central Intelligence Agency |
| 17. FATHER'S NAME (First, Middle, Last): Walter Wagner | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Rada | |
| 19a. INFORMANT'S NAME (Type/Print): Virginia B. Wagner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11304 Hawhill End, Potomac, Maryland 20854 | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park | 20c. LOCATION — City or Town, State: Rockville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas C. Sanders M00522 | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on sach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | PROSTATE CANCER | 2 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | METASTATIC MALIGNANCY | 16 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular Accident 1975

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Eugene P. Libré MD | 29c. LICENSE NUMBER: D04470 | 29d. DATE SIGNED (Month, Day, Year): 9/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EUGENE P. LIBRE MD | 10400 Connecticut Ave Kensington, MD 20895 | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

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UNKNOWN #89-162

Itmes:23 thru 28f per ME G-656
10-18-89 cm

89 25958

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL-DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FARRELL JOAN WOLFSON
2. DATE OF DEATH — MONTH: 9 DAY: 3 YEAR: 1989
3. TIME OF DEATH: 7:22P M
4. SOCIAL SECURITY NUMBER: 220-46-4445
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 37 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov.6,1951
8. BIRTHPLACE (State or Foreign Country): Wash.,D.C.
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5901 Montrose Road
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Writer/Editor
16b. KIND OF BUSINESS/INDUSTRY: Federal Government
17. FATHER'S NAME (First, Middle, Last): Irvin A. Wolfson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Sachs
19a. INFORMANT'S NAME (Type/Print): Irvin A. Wolfson (Father)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7011 Pyle Road; Bethesda, Md. 20817
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery
20c. LOCATION — City or Town, State: Adelphi, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A. Stone
22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 9-3-89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: subject jumped from building
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 12000 old Georgetown Rockville, Mont. Co., Md 2903

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 9-4-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201
31. DATE FILED (Month, Day, Year): SEP 06 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DNMN-18 Rev 1/89

89 25959

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William S. Yates | | | 2. DATE OF DEATH (Month, Day, Year): August 30 1989 | 3. TIME OF DEATH: 8:45 A. M |
| 4. SOCIAL SECURITY NUMBER: 263-10-5764 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 101 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 4, 1888 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Wilson Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg | | 9c. COUNTY OF DEATH: Montgomery |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Gaithersburg | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 301 Russell Ave. | | 10f. ZIP CODE: 20877 | | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman | | 16b. KIND OF BUSINESS/INDUSTRY: Education |
| 17. FATHER'S NAME (First, Middle, Last): Not Available | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Not Available | |
| 19a. INFORMANT'S NAME (Type/Print): Paul Yates | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3511 Landmark Trail, Palm Harbor, FL 34684 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery | | 20c. LOCATION — City or Town, State: Luray, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Williams | | 22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 Wisconsin Av., Washington, DC 20016 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Heart Block.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John F. Tauber MD

29c. LICENSE NUMBER: D085946

29d. DATE SIGNED (Month, Day, Year): August 30, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. John F. Tauber, 8218 Wisconsin Ave.; Bethesda, Maryland 20814

31. DATE FILED (Month, Day, Year): SEP 08 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

6

DHMH-16 Rev 1/89

89 25960

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELEANOR GILLESPIE ADAMS | | | 2. DATE OF DEATH (Month, Day, Year): August 13 1989 | 3. TIME OF DEATH: 1107P M |
| 4. SOCIAL SECURITY NUMBER: 240-12-9229 | 5. SEX: 1 ☐ M 2 XX F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): April 6, 1914 | 8. BIRTHPLACE (State or Foreign Country): Missouri |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: Prince Georges | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Upper Marlboro | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO | |
| 10e. STREET AND NUMBER: 5801 Woodyard Road, Lot #6 | | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): George Robertson Gillespie | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jesse Eflin | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Phillip Adams | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4902 Crofton Way, Tampa, Florida 33625 | | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bowersville City Cemetery | 20c. LOCATION — City or Town, State: Bowersville, Georgia | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack H. Brown | 22. NAME AND ADDRESS OF FACILITY: FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Md. 20781 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Augusto P. Rodriguez MD | D21230 | August 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriquez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 08 '89 | Julia Davidson-Ramsey |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH AGNES AMBROSE | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 2 / 89 | 3. TIME OF DEATH: 4:12 PM |
| 4. SOCIAL SECURITY NUMBER: 225-18-0049 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-11-15 | 8. BIRTHPLACE (State or Foreign Country): Washington, D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): LELAND MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: RIVERDALE | 9c. COUNTY OF DEATH: Prince George's | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: PRINCE GEORGE'S | 10c. CITY, TOWN OR LOCATION: COTTAGE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 4115 COTTAGE TERRACE | | 10f. ZIP CODE: 20722 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hosuewife | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Silvio Bertolini | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Madalena Faina | | | |
| 19a. INFORMANT'S NAME (Type/Print): Denise J. Ambrose (Daughter) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4115 Cottage Terrace, Cottage City, Maryland 20722 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | 20c. LOCATION — City or Town, State: Silver Spring, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark S. Brohawn | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MYOCARDIAL INFARCTION | 1 HOUR |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Arteriosclerotic Cardiovascular Disease | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Status Post Coronary Artery Bypass Surgery; Emphysema

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| N/A | M | 1 ☐ YES 2 ☐ ND | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D0 1852 | 9/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): PAUL A DEVORE MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 08 '89 | [signature] |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Puttner L. Alston
2. DATE OF DEATH (Month, Day, Year): 9 28 89
3. TIME OF DEATH: 1 30 PM
4. SOCIAL SECURITY NUMBER: 245-24-5143
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/3/02
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): PineView MANOR
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton MD
9c. COUNTY OF DEATH: Pr George

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: District Heights
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7231 Lansdale Street
10f. ZIP CODE: 20747
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 — College (1-4 or 5 +): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembly Line Worker
16b. KIND OF BUSINESS/INDUSTRY: Textile
17. FATHER'S NAME (First, Middle, Last): John Lyles
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elvira Unknown
19a. INFORMANT'S NAME (Type/Print): James Alston
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7231 Lansdale St.,District Heights,Md.20747
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory
20c. LOCATION — City or Town, State: Clinton,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Maryland 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: 12569
29d. DATE SIGNED (Month, Day, Year): 9/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. Nyman MD 4235 24th Ave Md 20744
31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson Rondeau

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Dorian | Laverne | Brown | 8-19-89 | 11:51PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 08 0282 | XX 1 M 2 F | 19 YRS. | | | Sept/3/1969 | Washington, DC |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 6823 W. Forest Road | Landover | Prince Georges Co. |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | Prince Georges | Landover | XX 1 YES 2 NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| &402 Landover Road # B | 20785 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| XX 1 Never Married 2 Married 3 Widowed 4 Divorced | XX 1 YES 2 NO — 16/Aug/88-2/may/89 | 1 YES XX 2 NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Unemployed | N/A |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Leal Brown | Theresa Haskins |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Theresa Brown | 7402 Landover Rd, Landover, Md 20785 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Washington National | Suitland Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Edward M Dudley | E.M. Dudley & Sons 3200 Rhode Island Avenue Mt. Rainier, Maryland 20712 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Contact gunshot wound to right side of head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 YES 2 NO | XX 1 YES 2 NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| XX 1 YES 2 NO | 1 Inpatient 2 ER/Outpatient 3 DOA | 4 Nursing Home 5 Residence XX 6 Other (Specify) Scene |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide XX 4 Homicide 5 Pending Investigation 6 Could not be determined | 8-19-89 | 11:45PM | 1 YES XX NO | Subject shot |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Apartment | 6823 W. Forest Rd., Landover, Prince Georges County, MD |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | 8-20-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Julia C. Goodin, M.D. | 111 Penn Street, Baltimore, MD 21201 VC |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 01 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25964

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

B

15

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elizabeth BOYER | | | 2. DATE OF DEATH (Month, Day, Year): August 31, 1989 | 3. TIME OF DEATH: 2:25A M |
| 4. SOCIAL SECURITY NUMBER: 062-26-0930 | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-20-31 | 6. BIRTHPLACE (State or Foreign Country): Puerto Rico |
| 9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | | 9c. COUNTY OF DEATH: P.G. |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: P.G. | 10c. CITY, TOWN OR LOCATION: Clinton | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 11300 Colorado Street | | 10f. ZIP CODE: 20735 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Statistical Clerk | | 16b. KIND OF BUSINESS/INDUSTRY: Census Bureau |
| 17. FATHER'S NAME (First, Middle, Last): Gabriel Perez | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Oflia Melina | |
| 19a. INFORMANT'S NAME (Type/Print): Richard E. Boyer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a-10f. | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory | | 20c. LOCATION — City or Town, State: Clinton, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark D. Lee | | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple organmetastasis of cancer — months

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Sepsis — days

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8-31-89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James K. Kim, M.D. | D16191 | 9-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 10694 Campus Way S., Largo, MD 20772

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 7 '89 | Julia Davidson-Randell |

DHMH-16 Rev 1/89

89 25965

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT K. BUTTS | | | 2. DATE OF DEATH: MONTH 08 DAY 23 YEAR 89 | 3. TIME OF DEATH: 1:40 A M |
| 4. SOCIAL SECURITY NUMBER: 577-26-9119 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): September 2, 1924 |
| 8. BIRTHPLACE (State or Foreign Country): Georgia | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | 9c. COUNTY OF DEATH: PRINCE GEORGE'S | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Temple Hill | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2715 | 10f. ZIP CODE: 20748 | 10g. CITIZEN OF WHAT COUNTRY? United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chef | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Butts | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Morse | | |
| 19a. INFORMANT'S NAME (Type/Print): Barbara Butts | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10e | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Mem. Park | 20c. LOCATION — City or Town, State: Landover, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. S. Jeffers | 22. NAME AND ADDRESS OF FACILITY: Frazier's Funeral Home WAshington, D.C. | 389 R.I. AvenueN.W. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multi system failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Carcinoma of Colon with metastasis
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rafik Abou-Nasr | 29c. LICENSE NUMBER: D37588 ~~BA1952~~ | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAFik Abou-NASR - Family Health Center, Prince George's Hosp

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25966

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ~~48~~ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES FORD BAYLOR / Charles Ford Baylor | | | | 2. DATE OF DEATH (Month, Day, Year): September 6, 1989 | 3. TIME OF DEATH: 2P M |
| 4. SOCIAL SECURITY NUMBER: 579-12-1247 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 15, 1920 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Residence: 4320 Ranger Avenue | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills | | 9c. COUNTY OF DEATH: Prince Georges |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | | 10c. CITY, TOWN OR LOCATION: Temple Hills | | 10d. INSIDE CITY LIMITS? XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4320 Ranger Avenue | | | 10f. ZIP CODE: 20748 | | 10g. CITIZEN OF WHAT COUNTRY? United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Sept. 1942/Nov. 1945 | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 year | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Transportation Officer | | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Dept. of Defense Andrews Air Force Base |
| 17. FATHER'S NAME (First, Middle, Last): Clarence Baylor | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Brooks | | |
| 19a. INFORMANT'S NAME (Type/Print): (wife) Emma Lou Davis Gould Baylor | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4320 Ranger Avenue, Temple Hills, Maryland 20748 | | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): National Harmony Memorial Park | | 20c. LOCATION — City or Town, State: Landover, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas Latney | | | 22. NAME AND ADDRESS OF FACILITY: Latney's Funeral Home 3831 Georgia Avenue, N.W.; Wash. D.C. 20011 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 26e. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 26d. DESCRIBE HOW INJURY OCCURED | | | |
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD | 29c. LICENSE NUMBER: D21230 | 29d. DATE SIGNED (Month, Day, Year): Sept 6, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D.; 5009 Rayburn Court, Temple Hills, Maryland 20748

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 12 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 25967

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELAINE CAMPBELL | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 01 89 | 3. TIME OF DEATH: 5 45AM M |
| 4. SOCIAL SECURITY NUMBER: 132-30-6928 | 5. SEX: 1 ☐ M 2 XX F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1/22/14 |
| 8. BIRTHPLACE (State or Foreign Country): England | | | |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | 9c. COUNTY OF DEATH: PRINCE GEORGE'S | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Greenbelt | 10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 22 Riggs Road | 10f. ZIP CODE: 20770 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): Alfred Warland | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Violet Manley | | |
| 19a. INFORMANT'S NAME (Type/Print): Gillian Chalmers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 192 Doyle Gardens London, N.W.England 3-5xk | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jimmy C Neal Sr | 22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD. 20785 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Diabetes mellitus,

DUE TO (OR AS A CONSEQUENCE OF):

c. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

d. Congestive Heart failure

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, COPD

S/P Tracheostomy

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: ECF 4 XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: AJ Khaira | 29c. LICENSE NUMBER: D-34616 | 29d. DATE SIGNED (Month, Day, Year): 9/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AJIT SINGH KHAIRA 3001 Hospital Dr. Cheverly, MD. 20785 | | |
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

P

(3)

09 2397

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25968

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CARLOS CARRINGTON | | | | 2. DATE OF DEATH (Month, Day, Year): 9 2 1989 | 3. TIME OF DEATH: 7:15A M |
| 4. SOCIAL SECURITY NUMBER: 578-92-7138 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 13 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 16, 1975 | 8. BIRTHPLACE (State or Foreign Country): Wash. D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 4913 Glassmanor Dr. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Oxon Hill | | 9c. COUNTY OF DEATH: Prince George's |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: District of Columbia | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Washington | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4030 Gault Place, N.E. | | 10f. ZIP CODE: 20019 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): Tyrone Carrington | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cheryl Smith | |
| 19a. INFORMANT'S NAME (Type/Print): Cheryl Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4030 Gault Place, N.E. Wash. D.C. | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park | 20c. LOCATION — City or Town, State: Landover, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Stewart, III | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd., N.E. Wash. D.C. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wounds (2) of head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 8 [X] Residence 8 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-2-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4913 Glassmanor Dr., Oxon Hill MD |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-18 Rev 1/89

89 25969

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Josephine Cross
2. DATE OF DEATH (Month, Day, Year): September 1, 1989
3. TIME OF DEATH: 8:45 a.m. M
4. SOCIAL SECURITY NUMBER: 579-84-5912
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 95 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-15-94
8. BIRTHPLACE (State or Foreign Country): Westernport, MD.
9a. FACILITY NAME (If not institution, give street and number): Greenbelt NsgCntr 7010 Greenbelt Rd
9b. CITY, TOWN OR LOCATION OF DEATH: Greenbelt Md 20770
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Riverdale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5905 Mustang Drive
10f. ZIP CODE: 20737
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Michael Patrick Cosgrove
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Loretta Cuff
19a. INFORMANT'S NAME (Type/Print): Francis J. Cross (Son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5905 Mustang Drive, Riverdale, Maryland 20737
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery
20c. LOCATION — City or Town, State: Clinton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend
22. NAME AND ADDRESS OF FACILITY: Francis GAsch's Sons Funeral Hôme, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | colon cancer | 1 y. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | sepsis due to | 10 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | decubitus ulcer | 6 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Till Bergemann M.D.
29c. LICENSE NUMBER: D04483
29d. DATE SIGNED (Month, Day, Year): ▶ 9-1-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TILL BERGEMANN MD 115 CENTERWAY, GREENBELT MD 20770
31. DATE FILED (Month, Day, Year): SEP 08 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson Anderson

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

(5)

89 25970

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GABRIEL CONSORTI | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 3 / 89 | 3. TIME OF DEATH: 11 56 PM |
| 4. SOCIAL SECURITY NUMBER: 579-54-0971 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8 30 30 | 8. BIRTHPLACE (State or Foreign Country): Teramo, Italy |
| 9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale | | 9c. COUNTY OF DEATH: Prince George's |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Hyattsville | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5418 15th Place | | 10f. ZIP CODE: 20782 | | 10g. CITIZEN OF WHAT COUNTRY? Prince George's |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (Italy) / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Barber | | 16b. KIND OF BUSINESS/INDUSTRY: Barber Shop |
| 17. FATNER'S NAME (First, Middle, Last): Peppino Consorti | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Maria DiFrancesco | | |
| 19a. INFORMANT'S NAME (Type/Print): Linda M. Shields (Daughter) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5418 15th Place Hyattsville, Maryland 20782 | | |
| 20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery | | 20c. LOCATION — City or Town, State: Adelphi, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark A Brohawn | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction — minutes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Arteriosclerotic Cardiovascular Disease — 4 years

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATN (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATN: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): n/a | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul A. DeVore MD Deputy Medical Examiner | D01852 | ▶ 9/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): PAUL A. DEVORE MD 4203 Queenslowy Rd Hyattsville MD 20781

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 08 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25971 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Howard Henry Compton, Jr. | | | | 2. DATE OF DEATH (Month, Day, Year): 09 13 89 | 3. TIME OF DEATH: 7:30 PM |
| 4. SOCIAL SECURITY NUMBER: 579-42-3704 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 08/29/32 | 8. BIRTHPLACE (State or Foreign Country): Washington, DC |
| 9a. FACILITY NAME (If not institution, give street and number): Gtr. Laurel Beltsville Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Prince George's |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Bowie | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6610 Willow Creek Road | | 10f. ZIP CODE: 20715 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Korean | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Realestate Broker | | 16b. KIND OF BUSINESS/INDUSTRY: Realestate Firm | |
| 17. FATHER'S NAME (First, Middle, Last): Howard Henry Compton, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Selma Johnston | |
| 19a. INFORMANT'S NAME (Type/Print): B. Adele Compton | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6610 Willow Creek Rd. Bowie, Maryland 20715 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State: Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A. Buchanan | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma lungs | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastasis / Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): NA

28b. TIME OF INJURY: — M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mirza Hussain Ali, Bais

29c. LICENSE NUMBER: D 13687

29d. DATE SIGNED (Month, Day, Year): ▶ 9-13-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MIRZA HUSSAIN ALI BAIG MD Suite 105 14201 Laurel Park Drive LAUREL MD 20707

31. DATE FILED (Month, Day, Year): SEP 15 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

8 N/A

DNMH-18 Rev 1/89

89 23711

Item:23,23pt 2, 27 per ME
10-6-89 cm

89 25972

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Carl Weldon Crawford, Jr. | | 2. DATE OF DEATH (Month, Day, Year): 9-11-89 | 3. TIME OF DEATH: 3:50PM M |
| 4. SOCIAL SECURITY NUMBER: 578-70-5608 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 20,1952 — 8. BIRTHPLACE (State or Foreign Country): Washington,D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 3165 Chestnut Grove Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Upper Marlboro | 9c. COUNTY OF DEATH: Prince Georges Co. | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Upper Marlboro | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3165 Chester Grove Rd. | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Customer Serv. Spec. | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): Carl Crawford, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie R. Jenkins | |
| 19a. INFORMANT'S NAME (Type/Print): Deborah Simmonds | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9508 Pin Oak Street Clinton, MD. 20735 | | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery | 20c. LOCATION — City or Town, State: Suitland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph B. Jenkins | 22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474Landover Rd. Landover, Md. 20785 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or reapiratory arreat, shock, or haart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Fatty Liver
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic Alcohol Abuse
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Narcotic Use

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-12-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall SEP 13 '89 Julia Davidson-Randall | |

OHMH-16 Rev 1/89

89 25973

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDNA VIRGINIA DAVIS | | 2. DATE OF DEATH (Month, Day, Year): August 30, 1989 | 3. TIME OF DEATH: 1 A. M |
| 4. SOCIAL SECURITY NUMBER: 578-32-1275 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 17, 1903 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 6014 Purdun Drive | 9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills | 9c. COUNTY OF DEATH: Prince Georges | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: District | 10b. COUNTY: of Columbia | 10c. CITY, TOWN OR LOCATION: Washington | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3403 Wheeler Road, S.E. | 10f. ZIP CODE: 20032 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last): James G. Goines | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Butcher | | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy E. Washington | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6014 Purdan Drive, Temple Hills, MD. | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery | 20c. LOCATION — City or Town, State: Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Stewart, III | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Road, N.E. Wash. D.C. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD | 29c. LICENSE NUMBER: d 21230 | 29d. DATE SIGNED (Month, Day, Year): August 30, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs MD. 20748 | | |
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

HELEN DAVIS

89 25974

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen Davis | | | 2. DATE OF DEATH (Month, Day, Year): September 2, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: Not Stated | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): February 21, 1916 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): 5610 Chesterfield Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Camp Springs | | 9c. COUNTY OF DEATH: Prince George |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Virginia | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Vernon Hill | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Route 1 Box | | 10f. ZIP CODE: 24597 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | | 16b. KIND OF BUSINESS/INDUSTRY: Farm |
| 17. FATHER'S NAME (First, Middle, Last): John B. Dixon | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Dixon | | |
| 19a. INFORMANT'S NAME (Type/Print): Carolyn Jones | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 9A. | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Church Cemetery | | 20c. LOCATION — City or Town, State: Halifax, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. J. Sellers | | 22. NAME AND ADDRESS OF FACILITY: 389 R.I. Avenue N.W. Frazier's Funeral Home Washington, D.C. 20001 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. inanition

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. metastatic colon cancer

DUE TO (OR AS A CONSEQUENCE OF):

c. liver metastases

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Dalal Haidak MD | D17605 | 9/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): D T Haidak MD Clinton MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

DNMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

(10)

89 2537

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25975
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rosella Delilly
2. DATE OF DEATH (Month, Day, Year): August 31, 1989
3. TIME OF DEATH: 3:25 M
4. SOCIAL SECURITY NUMBER: 578-46-1527
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): November 19, 1916
8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): DOCTOR HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: Good Luck
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Mitchellville
10d. INSIDE CITY LIMITS? ☒ 1 ☐ YES ☒ 2 ☐ NO
10e. STREET AND NUMBER: 10403 Meadows Ridge Ct.
10f. ZIP CODE: 20716
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: XXXX
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: XXX
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Nurse
16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): George Drake
18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Walker
19a. INFORMANT'S NAME (Type/Print): Frances D. Crawford
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 9A.
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat'L Cemetery
20c. LOCATION — City or Town, State: Laurel , Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. J. Sellers
22. NAME AND ADDRESS OF FACILITY: 389 R.I. AVenueN.W. Frazier's Funeral HOme Washington,D.C.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diabetic arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD
29c. LICENSE NUMBER: D21230
29d. DATE SIGNED (Month, Day, Year): August 31, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748
31. DATE FILED (Month, Day, Year): SEP 11 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(2)

OHMH-18 Rev 1/89

89 25976

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary K Dovnarovich | | 2. DATE OF DEATH (Month, Day, Year): 9 12-89 | 3. TIME OF DEATH: 9a A M |
| 4. SOCIAL SECURITY NUMBER: 129-26-6193 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/15/20 |
| 8. BIRTHPLACE (State or Foreign Country): Russia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | 9c. COUNTY OF DEATH: Prince George | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryalnd | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Laurel | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 13301 Arden Way | 10f. ZIP CODE: 20708 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Kuzmin Stenzenko | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marfa Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Louise Werner | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7304 Louise Lane, Lanham Maryland 20706 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Vladimirs Cemetery | 20c. LOCATION — City or Town, State: Jackson, New Jersey | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home Inc. 7601 Sandy Spring Rd, Laurel MD 20707 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Encephalopathy - Hypoglycemic, Hyperemic | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Insulin Dependent Diabetes | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): d. Manic Depression | |
| | DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William A. Warren MD | 29c. LICENSE NUMBER: D13916 | 29d. DATE SIGNED (Month, Day, Year): 9/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WA Warren 321 Prince Leap St Laurel, Md 20707 | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

(10)

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Pages ... must be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Kate ~~Kate~~ Edwards | | | 2. DATE OF DEATH (Month, Day, Year): 8 / 31 / 89 | 3. TIME OF DEATH: 10:45a M |
| 4. SOCIAL SECURITY NUMBER: 578 04 5519 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/20/'12 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | | 9c. COUNTY OF DEATH: Prince George's |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges' | 10c. CITY, TOWN OR LOCATION: Clinton | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 8600 Mike Shapiro Drive #205 | | 10f. ZIP CODE: 20735 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+): none | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Domestic | |
| 17. FATHER'S NAME (First, Middle, Last): Tim Davis | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Melvin Moore | |
| 19a. INFORMANT'S NAME (Type/Print): Roberta Jenifers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 Carmody Hills Dr., Capital Hts., MD. 20743 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moses Cemetery | 20c. LOCATION — City or Town, State: Lothian, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martell Adams | 22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home, P.A. Aquasco Road, Aquasco, MD. 20608 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gm Negative Peptic Ulcer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Gm Negative Bacteremia Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. UTI, Renal Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Senility | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Drug Toxicity; Pyelonephritis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number; City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Abul Hasan Ancalli MD 8926 Woodyard Rd & 101 Clinton MD 20735 | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 25978

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALBERTA L. ERVIN | | | 2. DATE OF DEATH Month: 09 Day: 03 Year: 89 | 3. TIME OF DEATH: 12.20A M |
| 4. SOCIAL SECURITY NUMBER: 577-22-9227 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-4-20 | 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: PRINCE GEORGE'S | 10c. CITY, TOWN OR LOCATION: LANDOVER | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO XX |
| 10e. STREET AND NUMBER: 1123 NALLEY ROAD #213 | | 10f. ZIP CODE: 20785 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced X | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO XX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO XX Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LAUNDRY ATTENDANT | 16b. KIND OF BUSINESS/INDUSTRY: DRY CLEANING | |
| 17. FATHER'S NAME (First, Middle, Last): CLEVUS BROOKS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE KING | |
| 19a. INFORMANT'S NAME (Type/Print): LOLA MAYO | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 CINDY LANE#204 SEAT PLEASANT, MARYLAND 20743 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK | 20c. LOCATION — City or Town, State: LANDOVER, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: P.E. Taylor | | 22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrhythmias | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Severe Metabolic Acidosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Septic Shock. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Status Post Cholecystectomy for Acute Cholecystitis
End Stage Renal Disease Hypotension
History of Supraventricular Arrhythmias

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D13987 | 29d. DATE SIGNED (Month, Day, Year): 9/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JASWINDER S. SAHU 7525 GREENWAY CENTER DR. GREENBELT MD 20770

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 15 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMN-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HERTHEL K. FAWBUSH | | 2. DATE OF DEATH (Month, Day, Year): 8-30-89 | 3. TIME OF DEATH: 1030 AM |
| 4. SOCIAL SECURITY NUMBER: 513-22-4171 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-15-03 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 5803 Longfellow Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale | 9c. COUNTY OF DEATH: Prince George's | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Cheverly | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3119 Laurel Avenue | 10f. ZIP CODE: 20785 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Person | 16b. KIND OF BUSINESS/INDUSTRY: Dress shop | |
| 17. FATHER'S NAME (First, Middle, Last): John H. Thurman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Strickler | | |
| 19a. INFORMANT'S NAME (Type/Print): Earl A. Fawbush | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3119 Laurel Avenue, Cheverly, Md. 20785 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mat D Bohn | 22. NAME AND ADDRESS OF FACILITY: FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Balt. Ave., Hyattsville, Md. 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Cardiovascular Disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul A. DeVore MD Deputy Medical Examiner | D01852 | ▶ 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 08 89 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

89 25980

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Mabel Virginia FORCUM
2. DATE OF DEATH (Month, Day, Year): September 4, 1989
3. TIME OF DEATH: 1:30 PM
4. SOCIAL SECURITY NUMBER: 577-40-5832
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 95 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-06-1893
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): AMI Doctors' Hosp. of Pr. Geo. County
9b. CITY, TOWN OR LOCATION OF DEATH: Lanham
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Virginia
10b. COUNTY: Fairfax
10c. CITY, TOWN OR LOCATION: Annandale
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4521 Casablanca Court
10f. ZIP CODE: 22003
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+): ----------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Washington Suburban Sanitary Commission
17. FATHER'S NAME (First, Middle, Last): James B. Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene V. Burke
19a. INFORMANT'S NAME (Type/Print): Jack Forcum /son/
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4521 Casablanca Court, Annandale, Virginia 22003
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Riverview Cemetery
20c. LOCATION — City or Town, State: Charlottesville, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A Bahan
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Md. 20781

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ~~metabolic~~ acidosis Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ~~metabolic~~ acidosis Renal failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Gangrenous small bowel
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jack Thorn
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 9-04-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ZORAYDA M. LEE-LLACER 8118 good luck rd. Lanham md 8909 old Branch ave Clinton md 20735
31. DATE FILED (Month, Day, Year): SEP 08 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25981

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leona C Forame | | | | 2. DATE OF DEATH (Month, Day, Year): August 24 89 | 3. TIME OF DEATH: 920 M |
| 4. SOCIAL SECURITY NUMBER: 578-16-4624 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): Feb/19/14 | 8. BIRTHPLACE (State or Foreign Country): Washington DC |
| 9a. FACILITY NAME (If not institution, give street and number): 2411 Fort Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Suitland | | 9c. COUNTY OF DEATH: Prince George | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Suitland | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 2411 Fort Drive | | 10f. ZIP CODE: 20746 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): operator | | 16b. KIND OF BUSINESS/INDUSTRY: printing | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Colea | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Yorio | | | |
| 19a. INFORMANT'S NAME (Type/Print): Leo R. Forame | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2411 Fort Drive Suitland MD 20746 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill | | 20c. LOCATION — City or Town, State: Suitland MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Melanie Wilhelm | | 22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home, Inc Suitland MD 20746 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Augusto P. Rodriguez MD | D21230 | August 26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD. 5009 Raytown Ct. Cpv Md 20748

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 31 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 52881

89 25982

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Roland N. Grauel | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 3 1989 | 3. TIME OF DEATH: 10:00 A M |
| 4. SOCIAL SECURITY NUMBER: 577-05-7388 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 26, 1902 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 919 Montgomery Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: PG | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | | 10c. CITY, TOWN OR LOCATION: Laurel | | 10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 919 Montgomery Street | | | 10f. ZIP CODE: 20707 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): John Grauel | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Gaither | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mabel Grauel | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 Montgomery Street Laurel, MD 20707 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. [illegible] Paul's Cem | | 20c. LOCATION — City or Town, State: Fulton, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma - lung

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Old age

DUE TO (OR AS A CONSEQUENCE OF):

c. Arteriosclerotic cardio vascular Dzm

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D13671

29d. DATE SIGNED (Month, Day, Year): ▶ 9-6-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B.P. MANETHWALA MD

31. DATE FILED (Month, Day, Year): SEP 08 89

32. REGISTRAR'S SIGNATURE: [signature] Julia Gordon-Randall

DHMH-18 Rev 1/89

88 52385

Items:23 thru 28f per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25983 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| JANET | GRIFFIN | 8 26 89 | 11:28 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 079-44-9734 | 1 ☐ M 2 ☒ F | 38 YRS. | | | July 14, 1951 | Kentucky |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Malcolm Grow USAF Medical Center | Camp Springs | Prince George's |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Prince George's | Forrestville | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3225 Walters Lane | 20747 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 4 | Housewife | Own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Charles E. Cobb | Martha B. Kendrick |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John C. Griffin | 3225 Walters Lane Forrestville, Maryland 20747 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | J. William Lees Sons | Washington, D.C. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| John F Bold | McGuire Funeral Service 7400 Georgia Ave. N.W. Washington, D.C. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Desipramine Intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 8-26-89 | M | 1 ☐ YES 2 ☐ NO | Subject ingested drugs |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 3223 Walters Lane Forestville, P.G. Co., Md. |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell, M.D. | OCME | 8-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D. 111 Penn Street Baltimore, Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 6'89 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 25984
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leona Rabbit GRIFFITH | | | 2. DATE OF DEATH (Month, Day, Year): September 6, 1989 | 3. TIME OF DEATH: 6:20 AM M |
| 4. SOCIAL SECURITY NUMBER: 220-46-3512 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 26, 1897 | 8. BIRTHPLACE (State or Foreign Country): Washington, DC |
| 9a. FACILITY NAME (If not institution, give street and number): AMI Doctor's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | | 9c. COUNTY OF DEATH: Prince Georges |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: University Park | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6914 Oakridge Road | | 10f. ZIP CODE: 20782 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Dept. of Transportation |

| | | | |
|---|---|---|---|
| 17. FATHER'S NAME (First, Middle, Last): James William Rabbit | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Holly Ethel Stephens | |
| 19a. INFORMANT'S NAME (Type/Print): Alden McKim Crane | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6914 Oakridge Road, University Park, MD 20782 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rockville Union Cemetery | 20c. LOCATION — City or Town, State: Rockville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas C. Sanders M00522 | | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. congestive Heart Failure | 3 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. occlusive vascular Disease, Tibial arteries | 3 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypertensive Cardiovascular Disease | 2 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Pneumonia, Right Lung | 3 weeks |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel J.N. Sugar, MD | 29c. LICENSE NUMBER: D 12086 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL J.N. SUGAR M.D 4637 EASTERN AVENUE, MT. RAINIER, MD. 20712

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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89 2598

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25985

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VALERIE J. GIBSON | | | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 03 89 | 3. TIME OF DEATH: 12 50PM M |
| 4. SOCIAL SECURITY NUMBER: 579 86 8904 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 30 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 15,1959 | 8. BIRTHPLACE (State or Foreign Country): Washington,D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGE'S | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Capitol Heights | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 51 Akin Avenue | 10f. ZIP CODE: 20743 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Data Processor | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Government | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL GIBSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH BROWN | |
| 19a. INFORMANT'S NAME (Type/Print): RUTH GIBSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6602 G Street, Seat Pleasant, Md. 20743 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/11/89 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | 20c. LOCATION — City or Town, State: Brentwood,Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Alex S Pope Jr. 174 | | 22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue, SE.DC 20020 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADULT RESPIRATORY DISTRESS SYNDROME | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ACUTE BRONCHO PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D14399 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): SEP 12 '89 | 32. REGISTRAR'S SIGNATURE | |

DHMH-16 Rev 1/89

89 25982

89 25986

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lawrence Aloysius GRADY | | 2. DATE OF DEATH (Month, Day, Year): September 11, 1989 | 3. TIME OF DEATH: 8:20P M |
| 4. SOCIAL SECURITY NUMBER: 578-50-5191 | 5. SEX: 1 ☐ M 2 ☐ F — X | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04/13/38 |
| 8. BIRTHPLACE (State or Foreign Country): Washington, DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Doctors Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | 9c. COUNTY OF DEATH: Prince George's | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Brentwood | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3712 Bladensburg Road, Apt. #1 | 10f. ZIP CODE: 20722 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Peacetime | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): ---------- | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Route Salesman | 16b. KIND OF BUSINESS/INDUSTRY: Retail | |
| 17. FATNER'S NAME (First, Middle, Last): William F. Grady | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn L. Jenkins | | |
| 19a. INFORMANT'S NAME (Type/Print): Robyn M. Daugherty | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9048 Rhode Island Ave., College Park, MD 20740 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Vets. Cemetery | 20c. LOCATION — City or Town, State: Cheltenham, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A Buchanan | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave, Hyattsville, MD 20781 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Respratory failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Cardiac Anythmias.

DUE TO (OR AS A CONSEQUENCE OF):

d. Congestive heart failure

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ Sept 11, 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ciro Montanez 3388 Dodge Park Road Landover, MD 20785

31. DATE FILED (Month, Day, Year): SEP 15 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(6) IVA

DHMH-18 Rev 1/89

89 25987

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATHERINE PEARL GEORG

2. DATE OF DEATH: MONTH 9 DAY 2 YEAR 89

3. TIME OF DEATH: 16:40 PM

4. SOCIAL SECURITY NUMBER: 213-74-5666

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): OCT. 25, 1903

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): GREATER LAUREL BELTSVILLE HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: LAUREL

9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: ANNE ARUNDEL

10c. CITY, TOWN OR LOCATION: LAUREL

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 3339 GRUMPTON SO.

10f. ZIP CODE: 20707

10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 7
College (1-4 or 6+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): BURCHARD HAYES BITTINGER

18. MOTNER'S NAME (First, Middle, Maiden Surname): AMELIA CAROLINE KRAUSE

19a. INFORMANT'S NAME (Type/Print): ROBERT C. GEORG

19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3339 GRUMPTON SO. LAUREL, MARYLAND 20707

20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other piece): FORT LINCOLN CEMETERY

20c. LOCATION — City or Town, State: BRENTWOOD, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC.
500 UNIVERSITY BLVD.,W. SIL.SPR.,MD. 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASPIRATION PNEUMONIA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Kendal MD

29c. LICENSE NUMBER: 036716

29d. DATE SIGNED (Month, Day, Year): 9/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8317 CHERRY LANE LAUREL, MD 20707

31. DATE FILED (Month, Day, Year): SEP 8 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Naomi E. HUMMEL | | | | 2. DATE OF DEATH (Month, Day, Year): September 8, 1989 | 3. TIME OF DEATH: 2:15P M |
| 4. SOCIAL SECURITY NUMBER: 165-14-4145 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 3, 1896 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): AMI Doctor's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | | 9c. COUNTY OF DEATH: Prince George | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Lanham | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 5615 Haddon Drive | | 10f. ZIP CODE: 20706 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | | 16b. KIND OF BUSINESS/INDUSTRY: Banking | |
| 17. FATHER'S NAME (First, Middle, Last): Franklin Warmkessel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Meyers | | | |
| 19a. INFORMANT'S NAME (Type/Print): Emma Jane Fisbeck | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10. | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | | 20c. LOCATION — City or Town, State: Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres. | | 22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or raspiratory arreat, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrovascular Thrombosis, | 11 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Cerebral Atherosclerosis | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular Disease | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William D. Rosson | | ▶ 9/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William D. Rosson, MD 5701 85th Ave, New Carrollton, MD 20784

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 14 '89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALMA HANION | | 2. DATE OF DEATH (Month, Day, Year): 09 12 1989 | 3. TIME OF DEATH: 6:50p. M |
| 4. SOCIAL SECURITY NUMBER: 064-34-6867 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-25-22 |
| 8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 5028 Silver Hill Court #102 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Suitland | 9c. COUNTY OF DEATH: PRINCE GEORGE'S |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: PRINCE GEORGE'S | 10c. CITY, TOWN OR LOCATION: FORESTVILLE | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5028 SILVER HILL COURT #102 | | 10f. ZIP CODE: 20747 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGH SCHOOL; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | 16b. KIND OF BUSINESS/INDUSTRY: DEPARTMENT STORE |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM WADE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): CHARLES HANION | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5028 SILVER HILL COURT #102 FORESTVILLE,MD. 20747 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINCOLN MEMORIAL | 20c. LOCATION — City or Town, State: SUITLAND, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: B. E. Taylor | | 22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Diabetic arteriosclerotic cardiovascular | |
| | DUE TO (OR AS A CONSEQUENCE OF): XXXXXXXXXXXXXXXXXX | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD | 29c. LICENSE NUMBER: D21230 | 29d. DATE SIGNED (Month, Day, Year): 9/12/1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD | | |
| 31. DATE FILED (Month, Day, Year): SEP 15 89 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randolph | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Humberto Iglesias | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 11, 1989 | 3. TIME OF DEATH: 9:52 M |
| 4. SOCIAL SECURITY NUMBER: 579-50-8692 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/11/26 | 8. BIRTHPLACE (State or Foreign Country): Cuba |
| 9a. FACILITY NAME (If not institution, give street and number): Bowie Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bowie | | 9c. COUNTY OF DEATH: Prince George's |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Bowie | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4409 Orangewood Lane | | 10f. ZIP CODE: 20715 | | 10g. CITIZEN OF WHAT COUNTRY? Cuba |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: Cuban | | 14. RACE — American Indian, Black, White, etc. Specify: |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waiter | | 16b. KIND OF BUSINESS/INDUSTRY: Mayflower Hotel |
| 17. FATHER'S NAME (First, Middle, Last): Cevereano Martin Iglesias | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Carmen Hernandez | | |
| 19a. INFORMANT'S NAME (Type/Print): Rosario Iglesias | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4409 Orangewood Lane, Bowie, Md 20715 | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | | 20c. LOCATION — City or Town, State: Silver Spring, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark A Bradham | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsvill, Md 20781 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial infarction | 5 minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] ATTENDING | 29c. LICENSE NUMBER: D00081 (MD) | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Anders MD 8814 Cessnawgbam Dr. Bowyatts MD 20720 | | |
| 31. DATE FILED (Month, Day, Year): SEP 15 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Fred D. Jones | | 2. DATE OF DEATH (Month, Day, Year): 8 30 89 | 3. TIME OF DEATH: 809 P M |
| 4. SOCIAL SECURITY NUMBER: 577-03-8177 | 5. SEX: X M 2 ☐ F | 6. AGE (In yrs. last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-17-04 |
| 8. BIRTHPLACE (State or Foreign Country): VA. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: Prince Georges | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: M.D. | 10b. COUNTY: P.G. | 10c. CITY, TOWN OR LOCATION: Clinton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 6109 Manor Road | 10f. ZIP CODE: 20735 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter | 16b. KIND OF BUSINESS/INDUSTRY: Washington Carpenter Union | |
| 17. FATHER'S NAME (First, Middle, Last): J. Fred Jones | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Flynn | | |
| 19a. INFORMANT'S NAME (Type/Print): Dora I. Wood | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7007 East Clinton St.,Clinton,Md. 20735 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeruane L Sales | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Md. 20735 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Colon Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Vascular Occlusion of Right Leg

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James L Cheley Jr MD | 29c. LICENSE NUMBER: D24351 | 29d. DATE SIGNED (Month, Day, Year): 8/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James L Cheley Jr MD 7700 Old Branch Ave Clinton Md 20735 | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSEMARIE B. JOHNSON | | 2. DATE OF DEATH (Month, Day, Year): 9 / 1 / 1989 | 3. TIME OF DEATH: 7:58A M |
| 4. SOCIAL SECURITY NUMBER: 578-82-5041 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 26 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 09/04/62 |
| 8. BIRTHPLACE (State or Foreign Country): Trinidad West Indies | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Prince George's General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly | 9c. COUNTY OF DEATH: Prince George's | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Brentwood | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3402 40th Place | 10f. ZIP CODE: 20722 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Asst. Communications Sup. | 16b. KIND OF BUSINESS/INDUSTRY: Dept. Store | |
| 17. FATHER'S NAME (First, Middle, Last): Martin Boodon | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Stella Bharath | | |
| 19a. INFORMANT'S NAME (Type/Print): Shareeza B. Peterson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7728 Frederick Road, W. Lanham Hills, MD 20784 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | 20c. LOCATION — City or Town, State: Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark A. Bolan | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 9-1-89 | 28b. TIME OF INJURY: 7:19A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Passenger of auto/bus collision | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3400 blk. Bladensburg Rd. Prince George's Co., MD | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randolph | |

DHMH-16 Rev 1/89

89-25993

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LILLIAN E JAMES | | | | 2. DATE OF DEATH (Month, Day, Year): 09 06 89 | 3. TIME OF DEATH: 9 25P M |
| 4. SOCIAL SECURITY NUMBER: 214-28-4211 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-26-27 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGE'S |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Laurel | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3745 Whiskey Bottom Road | | 10f. ZIP CODE: 20707 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last): Alexander Morgan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Taylor | | | |
| 19a. INFORMANT'S NAME (Type/Print): Jacqueline Collins | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8802 Hunting Lane, Laurel, MD 20708 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion Cemetery | 20c. LOCATION — City or Town, State: Laurel, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden | 22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home, P..A Rockville, MD 20850 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. – CARDIOPULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. – INTRACEREBRAL HEMORRHAGE | WEEKS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

– HEPATIC FAILURE
– ALCOHOLISM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| ATTENDING PHYSICIAN | D24093 | ▶ 9/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARC PARKHURST MD 7305 BALT AVE COLLEGE PARK MD 20740

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 12 '89 | Julia Davidson-Randall |

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DHMH-18 Rev 1/89

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89 25994

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELEANOR Nyman JENKINS | | 2. DATE OF DEATH (Month, Day, Year): 9 - 10 - 89 | 3. TIME OF DEATH: 1044P M |
| 4. SOCIAL SECURITY NUMBER: 579-12-6913 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 10, 1919 |
| 8. BIRTHPLACE (State or Foreign Country): Washington D.C. | | | |
| 8a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | 9c. COUNTY OF DEATH: Prince George | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Virginia | 10b. COUNTY: Fairfax | 10c. CITY, TOWN OR LOCATION: Falls Church | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 809 West Broad Street Apt. 123 | 10f. ZIP CODE: 22046 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical | 16b. KIND OF BUSINESS/INDUSTRY: CIA | |
| 17. FATHER'S NAME (First, Middle, Last): Arthur Nyman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanor Lanovoight | | |
| 19a. INFORMANT'S NAME (Type/Print): Cheryl A. Audish | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3804 Swan House Court, Burtonsville MD 20866 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rock Creek Cemetery | 20c. LOCATION — City or Town, State: Washington D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral HOme INc. 7601 Sandy Spring Road Laurel MD 20707 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Breast Carcinoma | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ovarian Carcinoma | Year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Dehydration | weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Anemia, Thrombocytopenia | mnths |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hypercalcemia
Hyponatremia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Pritam S. Saini MD | 29c. LICENSE NUMBER: D28998 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-11-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PRITAM S. SAINI MD 14333 LAUREL BOWIE RD SUITE 303 LAUREL MD 20708 | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25995
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Zelda Maree KARPEN | | | 2. DATE OF DEATH (Month, Day, Year): August 26, 1989 | 3. TIME OF DEATH: 6:30P M |
| 4. SOCIAL SECURITY NUMBER: 473-20-5070A | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 21, 1907 | 8. BIRTHPLACE (State or Foreign Country): Minnesota |
| 9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | | 9c. COUNTY OF DEATH: Prince George's |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Riverdale | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6375 67th Court | | 10f. ZIP CODE: 20737 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | | 16b. KIND OF BUSINESS/INDUSTRY: Retail | |
| 17. FATHER'S NAME (First, Middle, Last): Jacob J. Karpen | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary M. Karpen | | |
| 19a. INFORMANT'S NAME (Type/Print): Raymond Karpen (Brother) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6375 67th Court Riverdale, Maryland 20737 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, Virginia | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | <5 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PERFORATED VISCUS - ULCER/DIVERTICULITIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. POSSIBLE CARCINOMATOSIS SECONDARY TO LUNG MASS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. UNKNOWN | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MULTIPLE SCLEROSIS, UNAMBULATORY

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 115 CENTERWAY, GREENBELT, MD. 20770 | | |
| 31. DATE FILED (Month, Day, Year): 8/27/89 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 25996

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN Edward KENNEDY, Sr. | | | | 2. DATE OF DEATH (Month / Day / Year): 09 / 03 / 89 | 3. TIME OF DEATH: 6:00P M |
| 4. SOCIAL SECURITY NUMBER: 213-46-8841 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 41 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): August 21, 1948 | 8. BIRTHPLACE (State or Foreign Country): Washington, DC |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGE'S |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Mount Rainier, Maryland | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3703 35th Street | 10f. ZIP CODE: 20712 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 6+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber | 16b. KIND OF BUSINESS/INDUSTRY: Price Enterprises | |
| 17. FATHER'S NAME (First, Middle, Last): Edward W. Kennedy, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Adelaide Hadden | |
| 19a. INFORMANT'S NAME (Type/Print): Adelaide R. Kennedy (Mother) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6858 Riverdale Road, #T2 Lanham, Maryland 20706 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery | 20c. LOCATION — City or Town, State: Adelphi, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A Bateman | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, euch as cardiac or respiratory arrest, shock, or heart failure. Liet only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. | Pulmonary Cancer | 3 m |
| Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Brain Metastasis | 2 m |
| DUE TO (OR AS A CONSEQUENCE OF): c. | Multiple Bone Metastasis | 2 m |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Synchral Metastasis | 2 |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bilateral Pleural Effusion

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M |
| 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated.

| | | |
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| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: 41105 D.C. | 29d. DATE SIGNED (Month, Day, Year): ▶ 9-4-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OHANNES SAHAKIAN MD | 21346 MD | 5632 Annapolis Rd. Bladensburg, Md. 20710 |
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 25997 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joann M. Keagy | | | | | 2. DATE OF DEATH (Month, Day, Year): 8 / 26 / 89 | 3. TIME OF DEATH: 6:13 PM |
| 4. SOCIAL SECURITY NUMBER: 412 48 1886 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec/18/1930 | 8. BIRTHPLACE (State or Foreign Country): Tennessee |
| 9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton, Md. | | 9c. COUNTY OF DEATH: Prince George | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Prince George | | 10c. CITY, TOWN OR LOCATION: Ft. Washington | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 1309 Fillmore Road | | | 10f. ZIP CODE: 20744 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: own home | |
| 17. FATHER'S NAME (First, Middle, Last): Sherman McAlister | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eunice Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print): Richard C. Keagy | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 Fillmore Road Ft. Washington MD 20744 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State: Suitland MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Melanie Wilhelm | | | 22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc Suitland MD 20746 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest — 4 days

DUE TO (OR AS A CONSEQUENCE OF): COPD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, Chronic Pulmonary Insufficiency, Severe Depression

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|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D24945 | 29d. DATE SIGNED (Month, Day, Year) ▶ August 26, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7901 Old Branch Ave #409 Clinton, MD 20735 | | |
| 31. DATE FILED (Month, Day, Year): AUG 31 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 2397

89 25998

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dorothy A. King | | 2. DATE OF DEATH (Month, Day, Year): Sept 11 89 | 3. TIME OF DEATH: 4:16 PM |
| 4. SOCIAL SECURITY NUMBER: 109-05-5224 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hrs., Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11/19/12 |
| 8. BIRTHPLACE (State or Foreign Country): New York, NY | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 5308 Riverdale Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale | 9c. COUNTY OF DEATH: Prince George's | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Riverdale | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5308 Riverdale Road | 10f. ZIP CODE: 20737 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Intelligence | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt. | |
| 17. FATHER'S NAME (First, Middle, Last): Harold King | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Contento | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Henry King | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3884 Cherry Hill Road, Santa Maria, CA 93455 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Calvary Cemetery | 20c. LOCATION — City or Town, State: Queens, New York | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark G. Bisbaum | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Inf. DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic Myocardial Dis. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M |
| 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. | 29c. LICENSE NUMBER: D09975 | 29d. DATE SIGNED (Month, Day, Year): Sept. 11, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): | | |
| 31. DATE FILED (Month, Day, Year): SEP 15 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

(12) (IVA)

88 52038

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANN L LITTLETON | | | 2. DATE OF DEATH (Month / Day / Year): 09 / 02 / 89 | 3. TIME OF DEATH: 4 18PM M |
| 4. SOCIAL SECURITY NUMBER: 219-12-2747 | 5. SEX: 1 ☐ M 2 ☒ F (X) | 6. AGE (In yrs. last birthday): 67 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 03 28 22 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGES |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Upper Marlboro | 10d. INSIDE CITY LIMITS? 1 (XX) YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 8507 West Phalia Road | | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married (XX) 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 (XX) NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 (XX) NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Jessie Colbert | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Green | |
| 19a. INFORMANT'S NAME (Type/Print): Mary L. Pitt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 828 Avis Drive Upper Marlboro, MD. 20772 | | |
| 20a. METHOD OF DISPOSITION: 1 (X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Cemetery | 20c. LOCATION — City or Town, State: Laurel, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: J.B. Funeral Home 7474 Landover Rd. Landover, MD. 20785 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. End Stage Renal Disease | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Multiple cerebrovascular Accident; Seizure Disorder

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 (X) NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 (X) NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 (X) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 (X) Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 (X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Don H. Yablonowitz / Attending Physician | 29c. LICENSE NUMBER: D25079 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/3/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Don H. Yablonowitz 10300 Greenbelt Rd., # 101, Seabrook, Md 20706 | | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar | | |

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 26000
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Fowler, Lucile C.
2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89
3. TIME OF DEATH: 3:10 P M
4. SOCIAL SECURITY NUMBER: 578-20-5942
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/22/07
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): REGENCY
9b. CITY, TOWN OR LOCATION OF DEATH: Forestville, Maryland
9c. COUNTY OF DEATH: P. G.

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: CAPITOL HEIGHTS
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 40 BAYOU AVENUE
10f. ZIP CODE: 20743
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): operator
16b. KIND OF BUSINESS/INDUSTRY: telephone company
17. FATHER'S NAME (First, Middle, Last): Eli Cooley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Effie Mills
19a. INFORMANT'S NAME (Type/Print): Emily Poe
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 40 BAYOU AVE CAPITOL HEIGHTS MD 20743
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft Lincoln
20c. LOCATION — City or Town, State: Brentwood MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Melanie Wilhelm
22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc Suitland MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BREAST CANCER | 3½ YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William T. Tanner M
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 28 August 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Tanner MD 11701 Livingston Rd Fort Washington MD 20744
31. DATE FILED (Month, Day, Year): AUG 31 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 26001

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alfred R. Lapin, M.D.
2. DATE OF DEATH (Month, Day, Year): August 28, 1989
3. TIME OF DEATH: 2 P. M
4. SOCIAL SECURITY NUMBER: 154-12-7029
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-7-15
8. BIRTHPLACE (State or Foreign Country): N.J.
9a. FACILITY NAME (If not institution, give street and number): 11911 Green Tee Turn
9b. CITY, TOWN OR LOCATION OF DEATH: Upper Marlboro
9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: Upper Marlboro
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11911 Green Tee Turn
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 8
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Physician
16b. KIND OF BUSINESS/INDUSTRY: Medicine
17. FATHER'S NAME (First, Middle, Last): Jacques Lapin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Gevelin
19a. INFORMANT'S NAME (Type/Print): Terence W. Lapin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4853 Little Falls Rd., Arlington, Va. 22207
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory
20c. LOCATION — City or Town, State: Clinton, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): Hypertensive cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [/] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [/] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [/] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD
29c. LICENSE NUMBER: D21230
29d. DATE SIGNED (Month, Day, Year): August 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748
31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 26001

Items:23,27 per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 26002 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John S. Liles, Jr. | | | 2. DATE OF DEATH (Month, Day, Year): 9-12-89 | 3. TIME OF DEATH: 11:40AM M |
| 4. SOCIAL SECURITY NUMBER: 218-13-1715 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 18 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): August 24,1971 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Prince Georges General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly | | 9c. COUNTY OF DEATH: Prince Georges Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Upper Marlboro | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 8917 Simeon Court | | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Apprentice Plumber | 16b. KIND OF BUSINESS/INDUSTRY: Ace Heating & Plumbing | |
| 17. FATHER'S NAME (First, Middle, Last): John S. Liles, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Deborah A. Hare | |
| 19a. INFORMANT'S NAME (Type/Print): Deborah A. Hare | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8917 Simeon Ct., Upper Marlboro, Md. 20772 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery | 20c. LOCATION — City or Town, State: Clinton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill, Md. 20745 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. INTRACEREBRAL HEMORRHAGE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. VASCULAR MALFORMATION OF LEFT BASAL GANGLIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, MD | 111 Penn Street, Baltimore, MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): SEP 21 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ollie Litaker | | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 09 1989 | | 3. TIME OF DEATH: 3:25 p. M |
| 4. SOCIAL SECURITY NUMBER: 242-01-3073 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): April 26, 1907 | | 8. BIRTHPLACE (State or Foreign Country): So. Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Nursing Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel, Md. | | | 9c. COUNTY OF DEATH: Prince George | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | | 10c. CITY, TOWN OR LOCATION: Glen Arden | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 1506 - 7th Street | | | 10f. ZIP CODE: 20706 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic Worker | | | 16b. KIND OF BUSINESS/INDUSTRY: None | |
| 17. FATHER'S NAME (First, Middle, Last): Bryant Zigler | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth (unknown) | | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph Barton | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 148-1/2 Hawthorne Avenue, Newark, N.J. 07104 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park | | | 20c. LOCATION — City or Town, State: Landover, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest E. Wiesmann | | | 22. NAME AND ADDRESS OF FACILITY: Vann & Williams 4804 Ga. Ave.,N.W.,Wash.,D.C. | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrovascular accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Atherosclerosis

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | N/A | M | 1 ☐ YES 2 ☐ NO | N/A |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D24997 (MD) | ▶ 9/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LUIS A. CASAS 8317 CHERRY LA. LAUREL MD 20707

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 13 '89 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

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89 26004

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ruth R. Litteral | | 2. DATE OF DEATH (Month, Day, Year): 9 - 9 - 89 | 3. TIME OF DEATH: 10 15 M |
| 4. SOCIAL SECURITY NUMBER: 579-10-1350 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12-05-09 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Regency Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: Forestville Maryland | 9c. COUNTY OF DEATH: Prince Georges | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Mayo | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1608 Cliff Drive | 10f. ZIP CODE: 21106 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Henry Reid | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sallie Tacey | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret M. Becker | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4105 Forestville Rd., Forestville, Md. 20747 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery | 20c. LOCATION — City or Town, State: Washington, D.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George P. Kalas | 22. NAME AND ADDRESS OF FACILITY: George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Cardio-Pulmonary Arrest | 2mins. |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Fatal Arrhythmia | 5mins |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. Ischemic Cardiac Disease | 25 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | d. Arteriosclerotic Vascular Dis. | 35 yrs. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Colon Extreme Agitated Dementia
Carcinoma of Left Breast
S/P Cholecystectomy + S/P Hysterectomy

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Richard A. Farsm M.D. | D0 2237 | 9-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard A. Farsm MD. 9401 Indian Head Hwy Suite 360 Ft. Wash. Md. 20744

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 12 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 26005

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary Naomi Miley | | 2. DATE OF DEATH (Month, Day, Year): 08 25 89 | 3. TIME OF DEATH: 3:24 P M |
| 4. SOCIAL SECURITY NUMBER: 214-76-0857 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 28, 1918 |
| 8. BIRTHPLACE (State or Foreign Country): PA. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Ctr | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: Prince Georges Co. | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: P.G. | 10c. CITY, TOWN OR LOCATION: Clinton | 10d. INSIDE CITY LIMITS? 1 ☐ YES ☒ NO |
| 10e. STREET AND NUMBER: 9106 Pineview Lane | 10f. ZIP CODE: 20735 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY: N/A |

| | |
|---|---|
| 17. FATNER'S NAME (First, Middle, Last): William Phillip Miley | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Boyer |
| 19a. INFORMANT'S NAME (Type/Print): William F. Miley | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16829 Wesley Chapel Rd.,Monkton,Md.21111 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory | 20c. LOCATION — City or Town, State: Clinton,Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Maryland 20735 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ... Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UTI - Anemia - Hemorrhoids
Arteriosclerosis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: 12564 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 4235 26 [illegible] Md. 21748 | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 26005

89 26006

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Benjamin Moses | | | 2. DATE OF DEATH (Month, Day, Year): Aug 30, 1989 | 3. TIME OF DEATH: 4:35 a M |
| 4. SOCIAL SECURITY NUMBER: 223-26-5351 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-12-10 | 8. BIRTHPLACE (State or Foreign Country): NorthCarolina |
| 9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale | 9c. COUNTY OF DEATH: Prince George | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Riverdale | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 5815 Rittenhouse St. | | 10f. ZIP CODE: 20737 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO (XX) IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO (XX) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Government | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): William Tisdale | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5815 Rittenhouse St. Riverdale, MD. 20737 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial (XX) 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Cemetery | 20c. LOCATION — City or Town, State: Suitland, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph B. Jenkins | | 22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 LandoverRd. Landover, MD. 20785 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO RESPIRATORY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. RENAL FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. HYPERTENSIVE CARDIOVASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A Dalitter MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 8/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: |

DHMH-18 Rev 1/89

89 26006

89 26007

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Loretta Ikard Moates | | | | | 2. DATE OF DEATH (Month, Day, Year): 9-4-89 | | 3. TIME OF DEATH: 11:22PM M |
| 4. SOCIAL SECURITY NUMBER: 577-56-1009 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): March 22, 1943 | | 8. BIRTHPLACE (State or Foreign Country): Wash. D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Prince Georges General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly | | | | 9c. COUNTY OF DEATH: Prince Georges CO. |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | | 10c. CITY, TOWN OR LOCATION: Capitol Heights | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 328 Possum Court | | | 10f. ZIP CODE: 20743 | | | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 Years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | | | 16b. KIND OF BUSINESS/INDUSTRY: C & P Telephone Co. | | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Ikard | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabelle Smith | | |
| 19a. INFORMANT'S NAME (Type/Print): Michelle Lindsay | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 Kettering Dr., Upper Marlboro, MD. | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery | | 20c. LOCATION — City or Town, State: Washington D.C. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John T. Stewart, III | | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Road, N.E. Wash. D.C. | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiec or respiratory arreet, shock, or heart failure. List only ona cause on aach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: XXX 1 In Patient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 XXX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 9-4-89

28b. TIME OF INJURY: 4:53PM

28c. INJURY AT WORK? 1 ☐ YES 2 XX NO

28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/fixed object

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6700 Block Walker Mill Dr., Capital Heights, Prince Georges County, Maryland

Impact

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 9-5-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 08 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 26007

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE REBECCA McKNEW | | 2. DATE OF DEATH (Month / Day / Year): 9 / 7 / 89 | 3. TIME OF DEATH: 12:13A |
| 4. SOCIAL SECURITY NUMBER: 220-44-0327 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/20/1898 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) — RESIDENCE OF DECEDENT: Leland Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale | 9c. COUNTY OF DEATH: Prince George's | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Hyattsville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2911 Jamestown Road | 10f. ZIP CODE: 20782 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW I | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Department of Commerce | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph L. Cross | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie V. Connick | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert E. McKnew, Jr. /son/ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5802 32nd Avenue, Hyattsville, Md. 20782 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery | 20c. LOCATION — City or Town, State: Arlington, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack D Friend | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Md. 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Pulmonary Embolism | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Congestive Heart Failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. Atherosclerotic Cardiovascular Disease | |
| | d. Generalized atherosclerosis | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 9 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. attending | 29c. LICENSE NUMBER: D 19891 | 29d. DATE SIGNED (Month, Day, Year): 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABRAHAM B. DABELA 4404 Queensbury Rd. Riverdale MD

31. DATE FILED (Month, Day, Year): SEP 08 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(10) (IVA)

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN MARSH | | | 2. DATE OF DEATH (Month, Day, Year): 09 05 89 | 3. TIME OF DEATH: 4.30 A M |
| 4. SOCIAL SECURITY NUMBER: 579-44-0155 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan.4, 1936 | 8. BIRTHPLACE (State or Foreign Country): Noble Georgia |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | 9c. COUNTY OF DEATH: PRINCE GEORGE'S | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: D.C. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Washington, D.C. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 6635 13th Street, N.W. | | 10f. ZIP CODE: 20012 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES: No | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian | 16b. KIND OF BUSINESS/INDUSTRY: Library of Congress | | |
| 17. FATHER'S NAME (First, Middle, Last): George Leonard Marsh | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Jackson | | |
| 19a. INFORMANT'S NAME (Type/Print): Jan Marsh | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7340 Shadyglenn Terrace Capitol Heights, MD 20743 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Cemetery | 20c. LOCATION — City or Town, State: Landover, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derek E. Slocum | | 22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service 7400 Georgia Ave. N.W. Washington, D.C. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 2 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Decubitus Ulcer | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: multiple sclerosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Attending Physician | D21079 | ▶ 9/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jon H. Yablon Suite 10300 Greenbelt Rd # 101, Seabrook Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 11 '89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRIET F. MICCA | | 2. DATE OF DEATH (Month, Day, Year): 09 09 89 | 3. TIME OF DEATH: 5:40 A M |
| 4. SOCIAL SECURITY NUMBER: 142-05-2488 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-23-05 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Presidential Woods Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: Adelphi | 9c. COUNTY OF DEATH: Prince George's | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: New Jersey | 10b. COUNTY: Sussex | 10c. CITY, TOWN OR LOCATION: Newton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 32 Liberty Street | 10f. ZIP CODE: 07860 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1/12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Casualty Ins. | |
| 17. FATHER'S NAME (First, Middle, Last): Francis Cannata | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hulda Gansburg | | |
| 19a. INFORMANT'S NAME (Type/Print): Fr. Louis Micca, SAC | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 2437 Baltimore, Maryland 20213 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven | 20c. LOCATION — City or Town, State: Silver Spring, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home Inc. 11800 New Hampshire Ave., Silver Spring, MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIOPULMONARY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | METASTATIC PANCREATIC CANCER | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] ATTENDING PHY. | 29c. LICENSE NUMBER: D24093 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK PARKHURST MD 7305 BALT AVE COLLEGE PARK MD 20740 | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BRO. VINCENT F. McENTEE, F.S.C. | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 1, 1989 | 3. TIME OF DEATH: 10A M |
| 4. SOCIAL SECURITY NUMBER: 179-46-6511 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): AUGUST 23, 1916 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): 6011 AMMENDALE ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH: BELTSVILLE | | 9c. COUNTY OF DEATH: PRINCE GEORGE'S |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: PRINCE GEORGE'S | 10c. CITY, TOWN OR LOCATION: BELTSVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6011 AMMENDALE ROAD | | 10f. ZIP CODE: 20705 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5 + | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCHOOL ADMINISTRATOR | 16b. KIND OF BUSINESS/INDUSTRY: RELIGIOUS |
| 17. FATHER'S NAME (First, Middle, Last): HUGH McENTEE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLEN REIDY | |
| 19a. INFORMANT'S NAME (Type/Print): BROTHER GABRIEL CANNON, F.S.C. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6011 AMMENDALE ROAD BELTSVILLE, MARYLAND 20705 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHRISTIAN BROTHERS CEMETERY | 20c. LOCATION — City or Town, State: AMMENDALE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W. SIL.SPR.,MD.20901 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic obstructive pulmonary disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD | 29c. LICENSE NUMBER: D-21230 | 29d. DATE SIGNED (Month, Day, Year) ▶ SEPTEMBER 1, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AUGUSTO P. RODRIGUEZ, M.D. 5009 RAYBURN COURT CAMP SPRINGS, MARYLAND 20748

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 6 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CLENTIS McDANIEL | | | 2. DATE OF DEATH (Month, Day, Year): 09 08 89 | 3. TIME OF DEATH: 11:30A M |
| 4. SOCIAL SECURITY NUMBER: 244 20 3778 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept.23,1925 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON | | 9c. COUNTY OF DEATH: Prince Georges |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Temple Hills | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4423 23rd Pkwy #204 | | 10f. ZIP CODE: 20748 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Construction |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): JAMES MCDANIEL | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH COPELAND |
| 19a. INFORMANT'S NAME (Type/Print): FLORENCE MCDANIEL WIFE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4423 23rd Pkwy #204, Temple Hills, Maryland 20748 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) 9/13/89 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): COLIELD FUNERAL HOME | 20c. LOCATION — City or Town, State: WELDON, N.C. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alex S. Pope Jr. 174 | 22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue, S.E.DC 20020 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Head & Neck Cancer

DUE TO (OR AS A CONSEQUENCE OF):

c. S/P R.T. & Chemotherapy

DUE TO (OR AS A CONSEQUENCE OF):

d. Cachexia, Xerostomia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD, Attending | 29c. LICENSE NUMBER: D-24535 | 29d. DATE SIGNED (Month, Day, Year): 9/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L. BERWA, MD 1300 Mercantile Ln Landover MD 20785 | | |
| 31. DATE FILED (Month, Day, Year): SEP 12 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

03 2015

89 26013

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CLIFFORD MCDOWELL | | | 2. DATE OF DEATH (Month, Day, Year): 09 09 89 | 3. TIME OF DEATH: 7 25PM M |
| 4. SOCIAL SECURITY NUMBER: 240-40-2117-A | 5. SEX: X M 2 F | 6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04 27 31 | 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGES |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: PRINCE GEORGE'S | 10c. CITY, TOWN OR LOCATION: HYATTSVILLE | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER: 6133 OSBORN ROAD | | 10f. ZIP CODE: 20785 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 X Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): SECONDARY; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAINTENANCE | 16b. KIND OF BUSINESS/INDUSTRY: APARTMENT COMPLEX | |
| 17. FATHER'S NAME (First, Middle, Last): GEORGE McDOWELL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN KING | |
| 19a. INFORMANT'S NAME (Type/Print): DOROTHY WOODS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6133 OSBORN ROAD HYATTSVILLE, MD. 20785 | |
| 20a. METHOD OF DISPOSITION: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK | 20c. LOCATION — City or Town, State: LANDOVER, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: D. O. Taylor | | 22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anterolateral myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. upper gastrointestinal bleeding | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Esophageal varices | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Alcoholic abuse. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ishwari Kumar Bassi MD | 29c. LICENSE NUMBER: D37250 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 15 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 26014

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Chester ALTON McCready | | | 2. DATE OF DEATH (Month, Day, Year): September 12, 1989 | 3. TIME OF DEATH: 10:30 A M |
| 4. SOCIAL SECURITY NUMBER: 716-05-8420 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 06-27-1912 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Prince George's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly | | 9c. COUNTY OF DEATH: Prince George's |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Riverdale | | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6247 64th Avenue | | 10f. ZIP CODE: 20737 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW-2 | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No--- If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist | | 16b. KIND OF BUSINESS/INDUSTRY: Navy Department |
| 17. FATHER'S NAME (First, Middle, Last): John Russell McCready | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Ethel Treese | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Helen E. Vetterman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4118 Plaza Lane, Fairfax, Virginia 22033 | | |
| 20a. METNOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State: Brentwood, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark G. Bobbaun | | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Balt. Ave., Hyattsville, Md. 20781 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | Arteriosclerotic Cardiovascular disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Obesity

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Augusto P. Rodriguez MD | D21230 | September 13, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Medico P. Rodriguez MD, 5029 Baltimore Ave. Hyattsville Md 20781

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 15 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

(6) (IVA)

89 26015

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Everett Miller, Jr
2. DATE OF DEATH — MONTH: 9 DAY: 14 YEAR: 84
3. TIME OF DEATH: 3 39 A M
4. SOCIAL SECURITY NUMBER: 579-22-2770
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 12, 1925
8. BIRTHPLACE (State or Foreign Country): Washington, D.C.
9a. FACILITY NAME (If not institution, give street and number): 9115 Old Marlboro Pike
9b. CITY, TOWN OR LOCATION OF DEATH: Upper Marlboro
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Upper Marlboro
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9115 Old Marlboro Pike
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): Joseph Everett Miller Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eudora Milstead
19a. INFORMANT'S NAME (Type/Print): Carolyn E. Miller
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9115 Old Marlboro Pike, Upper Marlboro, MD. 20772
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
20c. LOCATION — City or Town, State: Cheltenham, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan S. Gearhart
22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. — 4308 Suitland Rd. Suitland, MD. 20746

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Metastatic Laryngeal Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: G. Clark Hollomon, M.D.
29c. LICENSE NUMBER: #
29d. DATE SIGNED (Month, Day, Year): 9/14/84
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 14314 Old Marlboro Pike Upper Marlboro MD. 20772
31. DATE FILED (Month, Day, Year): SEP 15 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-1a Rev 1/89

09 2015

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 26016
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Stephen Stephen Meholic Meholic Sr. | | | | | 2. DATE OF DEATH (Month, Day, Year): September 12, 89 | 3. TIME OF DEATH: 725P M |
| 4. SOCIAL SECURITY NUMBER: 360-18-6231 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 23, 1910 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 6507 Foster St. | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: District Heights | 9c. COUNTY OF DEATH: Prince Georges |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: District Heights | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6507 Foster Street | 10f. ZIP CODE: 20747 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Government |

| | |
|---|---|
| 17. FATNER'S NAME (First, Middle, Last): John Meholic Sr. | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Elizabeth Chismar |
| 19a. INFORMANT'S NAME (Type/Print): Anna Barna Meholic | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6507 Foster St. District Heights, MD. 20747 |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Byzantine Cemetery |
| 20c. LOCATION — City or Town, State: Bradenville, PA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan L. Gilbert | 22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD 20746 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arreat, shock, or heart feilure. List only one ceuse on eech lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | Arteriosclerotic cerebro-cardiovascular disease | |
| Sequantially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. DUE TO (OR AS A CONSEQUENCE OF): | |
| | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract infection, Diarrhea

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [/] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [/] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [/] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD | 29c. LICENSE NUMBER: D21230 | 29d. DATE SIGNED (Month, Day, Year): September 13/89 |

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 15 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Catherine Josephine NEWGENT | | 2. DATE OF DEATH (Month, Day, Year): September 3, 1989 | 3. TIME OF DEATH: 10:10 A M |
| 4. SOCIAL SECURITY NUMBER: 578-12-0028 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 19, 1912 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): AMI Doctors' Hosp. of Pr. Geo. County | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | 9c. COUNTY OF DEATH: Prince George's | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Bowie | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 11913 Lanham-Severn Road | 10f. ZIP CODE: 20715 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 8 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Baumann | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Fries | | |
| 19a. INFORMANT'S NAME (Type/Print): John C. Newgent | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3644 Patuxent River Rd. Davidsonville, MD 21035 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Memorial Gardens | 20c. LOCATION — City or Town, State: Davidsonville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres | 22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Edward F. Genesa MD | 29c. LICENSE NUMBER: D23657 | 29d. DATE SIGNED (Month, Day, Year): 9/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward F Genesa MD - 8118 Goodluck Rd. Lanham MD 20706 | | |
| 31. DATE FILED (Month, Day, Year): SEP 14 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 26017

Items:2,11,29d per ME G-656
10-30-89 cm

89 26018

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Nora Grace Parkins | | | | 2. DATE OF DEATH (Month, Day, Year): August 24, 89 (8-25-89) | 3. TIME OF DEATH: 1135P M |
| 4. SOCIAL SECURITY NUMBER: 577-70-1685 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov 23, 1924 | 8. BIRTHPLACE (State or Foreign Country): Jamaica |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): 2123 Ruatan St | 9b. CITY, TOWN OR LOCATION OF DEATH: Adelphi | 9c. COUNTY OF DEATH: Prince Georges |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Adelphi | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2123 Ruatan Street | | 10f. ZIP CODE: 20783 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School Grad; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Food Service Worker | 16b. KIND OF BUSINESS/INDUSTRY: Private Industry |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Samuel Harris | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Serphina Irons |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print): David Buchanan, Son | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2123 Ruatan Street, Adelphi, Maryland 20783 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Memorial Park | 20c. LOCATION — City or Town, State: Laurel, Maryland |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Washington, D,C, 20011 Johnson & Jenkins Inc., 716 Kennedy ST. NW |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Carcinoma of Ovary | 6 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D09975 | 29d. DATE SIGNED: Aug-25-1989 (Aug 27 1989) |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: [signature] |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

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DHMH-18 Rev 1/89

89 26019

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): David Wayne Price | | | | 2. DATE OF DEATH (Month, Day, Year): 9-4-89 | 3. TIME OF DEATH: 8:05 PM M |
| 4. SOCIAL SECURITY NUMBER: 217-92-5798 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 24 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 01/16/65 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel/Beltsville Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Prince Georges Co. |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Laurel | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 366 Old Line Avenue | | | 10f. ZIP CODE: 20707 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter-Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Martin J. Price | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alberta L. Reiber | | |
| 19a. INFORMANT'S NAME (Type/Print): Martin J. Price | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 366 Old LIne Ave, Laurel, Maryland 20707 | | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union Cemetery | | 20c. LOCATION — City or Town, State: Burtonsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home INc. 7601 Sandy Spring Rd Laurel MD 20707 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 ☐ NO | XX YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XXX 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 9-4-89 | 7:45PM | 1 ☐ YES XX NO | Occupant in auto accident |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Brockbridge Rd./Rt. 197,Laurel Laurel, Anne Arundel Co.MD |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 9-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 08 89 | [signature] |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Pamela Coressa Proctor | | 2. DATE OF DEATH (Month, Day, Year): 8-28-89 | 3. TIME OF DEATH: 3:10PM M |
| 4. SOCIAL SECURITY NUMBER: unknown | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 26 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07 01 '63 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Rt. 2, Box 263 E. | 9b. CITY, TOWN OR LOCATION OF DEATH: Brandywine | 9c. COUNTY OF DEATH: Prince Georges County | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Charles | 10c. CITY, TOWN OR LOCATION: Malcolm | 10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Route 2 Box 263-E | 10f. ZIP CODE: 20613 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): none | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Presser | 16b. KIND OF BUSINESS/INDUSTRY: Plastics | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas G. Proctor | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth H. Thompson | | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas G. Proctor | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rte. 2 Box 263-E Brandywine, MD. 20613 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St Peter's Catholic Ch Cem | 20c. LOCATION — City or Town, State: Waldorf, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martell Adams | 22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home Aquasco Road, Aquasco, MD. 20608 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Strangulation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX 1 YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX 1 YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence XX 6 Other (Specify) Scene-residence | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 XXX Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): UNKNOWN | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES XXX NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Subject strangled | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND: auto outside residence | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): FOUND:Rt. 2, Box263,Brandywine Prince Georges County, Maryland | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 8-29-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,Jr.,M.D. 111 Penn Street,Baltimore,Maryland 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH (Month, Day, Year) | | | 3. TIME OF DEATH |
| HARRY | EVERETT | PACE | | AUGUST, | 30 | 1989 | 7:54 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) |
| 486-16-5255 | 1 [X] M 2 [ ] F | 78 YRS. | | | 8-31-10 | | KY. |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
| Malcolm Grow Med. Cen. | Camp Springs | PG |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
| MD | PG | Suitland | 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
| 4816 Eastern Lane Apt #101 | 20746 | USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES 6/11/59: 6-17-65 | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 | 0 | Security Guard | Fed. Gov't |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| Murray Pace | Ollie-Belle Koon |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Julia Pace | Same as 10a-10f. |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Arlington Nat'l Cemetery | Arlington, Va. |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARRHYTHMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. RESPIRATORY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. VENTRICULAR ARRHYTHMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
| Deborah A. Zdor-North | | ▶ AUGUST 30, 1989 |

| | |
|---|---|
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
| DEBORAH A. ZDOR-NORTH, CAPT, USAF, MC | MALCOLM GROW USAF MEDICAL CENTER ANDREWS A F B, MD 20331-5300 |

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
| SEP 07 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): YA-MO PAIK
2. DATE OF DEATH (Month, Day, Year): 9 3 89
3. TIME OF DEATH: 6:30 AM
4. SOCIAL SECURITY NUMBER: 217-80-2970
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-20-24
8. BIRTHPLACE (State or Foreign Country): Korea
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Charles
10c. CITY, TOWN OR LOCATION: Waldorf
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Highway 925 S. Box 323F
10f. ZIP CODE: 20602
10g. CITIZEN OF WHAT COUNTRY? Korea
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Korean
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 8+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Kwang Chul Yang
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sae Sung Yeu
19a. INFORMANT'S NAME (Type/Print): Young K. Paik
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a-10f.
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens
20c. LOCATION — City or Town, State: Waldorf, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry road Clinton, Maryland 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MASSIVE ISCHEMIC STROKE — days.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CEREBRAL arteriosclerosis. — years

DUE TO (OR AS A CONSEQUENCE OF):

c. END STAGE OF MULTIPLE MYELOMA — Months.

DUE TO (OR AS A CONSEQUENCE OF):

d. Atherosclerotic coronary heart disease. — years.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LEFT HEMIPARESIS, CACHEXIA AND PSORIATIC ARTHRITIS
LABILE HYPERTENSION.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D12284
29d. DATE SIGNED (Month, Day, Year): SEPT. 3 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735

31. DATE FILED (Month, Day, Year): SEP 07 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 26023

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Lorenzo Carroll Pace

**2. DATE OF DEATH** (Month, Day, Year): September 10, 1989

**3. TIME OF DEATH**: 4:55 P. M

**4. SOCIAL SECURITY NUMBER**: 229-36-1411

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 59 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): June 28, 1930

**8. BIRTHPLACE** (State or Foreign Country): Virginia

**9a. FACILITY NAME** (If not institution, give street and number): 3034 Brinkley Rd., Apt. T-1

**9b. CITY, TOWN OR LOCATION OF DEATH**: Temple Hills

**9c. COUNTY OF DEATH**: Prince George's

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Prince George's

**10c. CITY, TOWN OR LOCATION**: Temple Hills

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 3034 Brinkley Rd., Apt. T-1

**10f. ZIP CODE**: 20748

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: Korea

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Engineer

**16b. KIND OF BUSINESS/INDUSTRY**: Federal Government

**17. FATHER'S NAME** (First, Middle, Last): Lorenzo D. Pace

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Eliza Price Jones

**19a. INFORMANT'S NAME** (Type/Print): Juanita M. DeSimone

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3015 Brinkley Station Dr. Temple Hills, Md. 20748

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Maryland Veterans Cemetery

**20c. LOCATION — City or Town, State**: Cheltenham, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ George P. Kalas

**22. NAME AND ADDRESS OF FACILITY**: George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill, Md. 20745

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | Arteriosclerotic cardiovascular disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [/] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [/] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [/] Residence 8 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 6 [ ] Could not be determined

**26a. DATE OF INJURY** (Month, Day, Year)

**26b. TIME OF INJURY** M

**26c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**26d. DESCRIBE HOW INJURY OCCURED**

**26e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**26f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [/] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Augusto P. Rodriguez MD

**29c. LICENSE NUMBER**: D 21230

**29d. DATE SIGNED** (Month, Day, Year): Sept. 11, 1989

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, Md.

**31. DATE FILED** (Month, Day, Year): SEP 12 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 26024

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME: RAY PATTERSON REESE | | 2. DATE OF DEATH (Month, Day, Year): 9-1-89 | 3. TIME OF DEATH: 2:45 PM |
| 4. SOCIAL SECURITY NUMBER: 578-48-9332 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 52 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): July 8, 1937 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale, | 9c. COUNTY OF DEATH: Prince George's | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: College Park | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5113 Kenesaw Street | 10f. ZIP CODE: 20740 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korean | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed | 16b. KIND OF BUSINESS/INDUSTRY: Air Cond. & Refrigeration | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Reese | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Joanne Vaughn | | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Ann Reese /wife/ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5113 Kenesaw Street, College Park, Md. 20740 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend | 22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PROSTATE SQ Cell Carcinoma | 10 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Stroke DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J Kelman MD | | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey Kelman 6125 Belcrest Rd, Hyattsville, Md | | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

25 IVA

89 26025

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VIVIAN S. REDDEN (VIVIAN S. Redden) | | | 2. DATE OF DEATH Month 9/6 Day 89 Year | 3. TIME OF DEATH 12:30 M |
| 4. SOCIAL SECURITY NUMBER: 577-20-5011 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): MAY 30, 1912 | 8. BIRTHPLACE (State or Foreign Country): VA. |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER LAUREL BELTSVILLE HOSP'T. | | 9b. CITY, TOWN OR LOCATION OF DEATH: LAUREL | | 9c. COUNTY OF DEATH: PRINCE GEORGES |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: PRINCE GEORGES | 10c. CITY, TOWN OR LOCATION: GREENBELT | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 17 B. PARKWAY RD. | | 10f. ZIP CODE: 20770 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CAFETERIA WORKER | 16b. KIND OF BUSINESS/INDUSTRY: BOARD OF EDUCATION | |
| 17. FATHER'S NAME (First, Middle, Last): ROBERT J. HALL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NANNIE REMMELS | |
| 19a. INFORMANT'S NAME (Type/Print): WILLIAM T. REDDEN JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3504 OREM DR., TEMPLE HILLS, MD. 20748 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY | 20c. LOCATION — City or Town, State: ARLINGTON, VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. W. Chambers MO0091 | | 22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. INC. , RIVERDALE, MD. 20737 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer, Metastatic

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew C. Kundrat M.D. | 29c. LICENSE NUMBER: D36716 | 29d. DATE SIGNED (Month, Day, Year): 9/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREW C. KUNDRAT M.D. 8317 CHERRY LANE, LAUREL, MD. 20707

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson |

12

DNMN-18 Rev 1/89

89 26026

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John A Shorter
4. DATE OF DEATH (Month, Day, Year): September 3, 1989
3. TIME OF DEATH: 350A M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 54 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): October 20, 1934
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: PrinceGeorges
10c. CITY, TOWN OR LOCATION: Landover
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2120 Columbia Place
10f. ZIP CODE: 20785
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed
16b. KIND OF BUSINESS/INDUSTRY: N/A

17. FATHER'S NAME (First, Middle, Last): Authur W. Shorter
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanor Washington

19a. INFORMANT'S NAME (Type/Print): Margret Redmon
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2120 Columbia Place

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park
20c. LOCATION — City or Town, State: Landover, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Tommy C. Neal Sr
22. NAME AND ADDRESS OF FACILITY: 7474 Lanover Road, J.B.JenkinsFuneralHome Landover, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Asthmaticlike cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD
29c. LICENSE NUMBER: D-21230
29d. DATE SIGNED (Month, Day, Year): September 3, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P Rodriguez MD 5009 Raymond St. Cheverly MD 20785

31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

09 26025

89 26027

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Richard Howard Sample | | 2. DATE OF DEATH (Month, Day, Year): 8-30-89 | 3. TIME OF DEATH: 8:25PM M |
| 4. SOCIAL SECURITY NUMBER: 212-04-6920 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 22 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-27-1967 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: Prince Georges Co. | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Charles | 10c. CITY, TOWN OR LOCATION: Waldorf | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 315 Pam Drive | 10f. ZIP CODE: 20603 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 19850198 7 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Richard L. Sample | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Gloria Ann Bell | | |
| 19a. INFORMANT'S NAME (Type/Print): Richard L. Sample | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 315 Pam Drive, Waldorf, Md. 20603 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crown Crest Memorial Park | 20c. LOCATION — City or Town, State: Clearfield, Penn. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward H. Mudd | 22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P.O. Box 156, Waldorf, Md. 20604-0156 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Stab wound of chest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [XX] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [XX] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [XX] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [XX] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [XX] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year): 8-30-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [XX] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject stabbed |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): MOBIL HOME | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 2, Box 189, Waldorf, Charles County, Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
[XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 8-31-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,M.D. 111 Penn Street,Baltimore,MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 06 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

Items:23 thru 28f per ME G-656
10-18-89 cm

89 26028

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mildred Cecelia Schultz | | | | 2. DATE OF DEATH: MONTH 8 DAY 31 YEAR 89 | | 3. TIME OF DEATH: 7:15 P.M |
| 4. SOCIAL SECURITY NUMBER: 220-32-6205 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-9-01 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 6403 Woodley Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | | 9c. COUNTY OF DEATH: Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: P.G. | | 10c. CITY, TOWN OR LOCATION: Clinton | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 6403 Woodley Road | | | 10f. ZIP CODE: 20735 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): John Phillip Cissel | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mida Smith Ziegler | | | |
| 19a. INFORMANT'S NAME (Type/Print): Barbara Susaraba | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6901 Ash Ct.Owings,Md.20736 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery | | 20c. LOCATION — City or Town, State: clinton,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Md. 20735 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 6 ☒ Residence 8 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8-31-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject drowned |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home (pool) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6403 Woodley Road Clinton, P.G. Co., Md. |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell, M.D. | OCME | ▶ 9-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 07 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 26020

89 26029

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Blanche G. Singer | | 2. DATE OF DEATH (Month, Day, Year): 9-4-89 | 3. TIME OF DEATH: 9:50AM |
| 4. SOCIAL SECURITY NUMBER: 577-40-4014 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-10-19 |
| 8. BIRTHPLACE (State or Foreign Country): Wash.D.C | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 8209 Old Branch Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: P.G. | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: M.D. | 10b. COUNTY: P.G. | 10c. CITY, TOWN OR LOCATION: Clinton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8209 Old Branch Avenue | 10f. ZIP CODE: 20735 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): C&P supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Communications | |
| 17. FATHER'S NAME (First, Middle, Last): Edward J. Goodwin | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Agnes Wolfe | | |
| 19a. INFORMANT'S NAME (Type/Print): Marie S. Walton | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 920 South River Landing, Edgewater, Md. 21037 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Washington Nat'l Cemetery | 20c. LOCATION — City or Town, State: Suitland, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark D. DuPuis | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrythmia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. History myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Cancer Right Thigh

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe Rheumatoid Arthritis.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D27902 | ▶ 9/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. CHANDRA. 9131 Piscataway Rd Clinton MD 20735.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 07 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 26030
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES LEON STEWART | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 3, 1989 | 3. TIME OF DEATH: 8:12 pM |
| 4. SOCIAL SECURITY NUMBER: 471-34-3069 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-12-34 | 8. BIRTHPLACE (State or Foreign Country): Minnesota |
| 9a. FACILITY NAME (If not institution, give street and number): Malcolm Grow USAF Med. Cen. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Camp Springs | | 9c. COUNTY OF DEATH: P.G. |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: M.D. | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Capital Heights | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 9407 Firtree Park St. | | 10f. ZIP CODE: 20743 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 12-29-52; 9-29-71 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | | 16b. KIND OF BUSINESS/INDUSTRY: Suitland VoTech. |
| 17. FATHER'S NAME (First, Middle, Last): Charles Edwin Stewart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florella Burnell | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret Stewart | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9407 Firtree Park St., Capital Heights, Md 20743 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md Veterans Cemetery | | 20c. LOCATION — City or Town, State: Cheltenham, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YES 2 X NO | HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | | | |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| FRANK P NORTH Capt, USAF, MC 389-76-8101 AFSC 9321 Malcolm Grow Med Ctr | | ▶ 03 SEPTEMBER 1989 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANK P. NORTH, CAPT, USAF, MC<br>MALCOLM GROW USAF MEDICAL CENTER<br>ANDREWS AFB, MD 20331-5300 | SEP 07 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 26030

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 26031
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HAZEL Marie SMOLARSKY | | | 2. DATE OF DEATH (Month, Day, Year): 8-31-89 | 3. TIME OF DEATH: 1 PM |
| 4. SOCIAL SECURITY NUMBER: 389-12-3411 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-28-13 | 8. BIRTHPLACE (State or Foreign Country): Wisconsin |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Md. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | | 9c. COUNTY OF DEATH: Prince Georges |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: PG | 10c. CITY, TOWN OR LOCATION: Clinton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7520 Surratts Road | | 10f. ZIP CODE: 20735 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dietician | 16b. KIND OF BUSINESS/INDUSTRY: Dietary | |
| 17. FATHER'S NAME (First, Middle, Last): Elmer Merten | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Bell Gossink | |
| 19a. INFORMANT'S NAME (Type/Print): Edward Smolarsky | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9306 Grandhaven Ave.,Upper Marlboro,Md.20772 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Md. 20735 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO RESPIRATORY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. BRACHIO CEPHALIC THROMBOSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(a) HYPERTENSION (2) [illegible] ASCVD

(b) DEPRESSION

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 26031

89 26032

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Willard Charles STRAUB, Sr. | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 9, 1989 | 3. TIME OF DEATH: 6:00A M |
| 4. SOCIAL SECURITY NUMBER: 105-03-6436 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 25, 1910 |
| 8. BIRTHPLACE (State or Foreign Country): New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number): AMI DOCTORS' HOSPITAL OF P.G. COUNTY | 9b. CITY, TOWN OR LOCATION OF DEATH: LANHAM, MARYLAND | 9c. COUNTY OF DEATH: PRINCE GEORGE'S | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Bowie | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 16044 English Oaks Ave. Apt.A | 10f. ZIP CODE: 20716 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Receiving Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Grocery | |
| 17. FATHER'S NAME (First, Middle, Last): Adolph Straub | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Johanna Wehner | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret T. Straub | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Our Lady of Sorrows Church Cem. | 20c. LOCATION — City or Town, State: West River, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Jr. | 22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYOCARDIAL INFARCTION | 7 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CARCINOMATOSIS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: K. Mathew MD | 29c. LICENSE NUMBER: D14799 | 29d. DATE SIGNED (Month, Day, Year): 9/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K.J MATHEW MD · 6510 KENILWORTH AVE. RIVERDALE, MD 20737 | | |
| 31. DATE FILED (Month, Day, Year): SEP 14 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 26033 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jerel Alton Scamehorn | | | 2. DATE OF DEATH: MONTH 09 DAY 07 YEAR 89 | 3. TIME OF DEATH: 7:45 AM | |
| 4. SOCIAL SECURITY NUMBER: — | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. 42 | 7. DATE OF BIRTH (Month, Day, Year): 09 07 89 | 8. BIRTHPLACE (State or Foreign Country): md. |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: Pr. Georges | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Charles | 10c. CITY, TOWN OR LOCATION: Waldorf | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3820 Lightarms Place | 10f. ZIP CODE: 20601 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — | College (1-4 or 5 +) — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) — | 16b. KIND OF BUSINESS/INDUSTRY — |
| 17. FATHER'S NAME (First, Middle, Last): John R. Scamehorn 3rd | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Connie J. Scamehorn | |
| 19a. INFORMANT'S NAME (Type/Print): JOHN ROBERT SCAMEHORN III | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3820 Lightarms Pl. Md. 20601 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): XXXXXXXXXXXXXXX OAKLAND | 20c. LOCATION — City or Town, State: Waldorf md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Will B Hallowell | | 22. NAME AND ADDRESS OF FACILITY: HUNTT FUNERAL HOME, INC. P.O. BOX 156 WALDORF, MD. 20604 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. premature delivery. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. premature rupture of membranes | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. same as above | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A. Majdi M.D | 29c. LICENSE NUMBER: AM9242199 | 29d. DATE SIGNED (Month, Day, Year): 9/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALI M. MAJDI 6188 OXON HILL ROAD OXON HILL MARYLAND 20745

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 26034

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RUTH E. TARTER | | | 2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 9,1989 | 3. TIME OF DEATH: 7 40PM M |
| 4. SOCIAL SECURITY NUMBER: 465-20-6069-D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 98 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): AUGUST 13, 1891 | 8. BIRTHPLACE (State or Foreign Country): TEXAS |
| 9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY | | 9c. COUNTY OF DEATH: PRINCE GEORGES |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: TEXAS | 10b. COUNTY: DALLAS | 10c. CITY, TOWN OR LOCATION: DALLAS | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6115 BERWYN LANE | | 10f. ZIP CODE: 75214 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): BENJAMIN SKINNER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANGELINA FRANKLIN NELSON | |
| 19a. INFORMANT'S NAME (Type/Print): MARGIE TARTER HICKS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 WEYMOUTH STREET UPPER MARLBORO,MARYLAND 20772 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RESTLAND MEMORIAL PARK | 20c. LOCATION — City or Town, State: DALLAS, TEXAS |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dayne T Ryburt M00335 | | 22. NAME AND ADDRESS OF FACILITY: ROBERT A. PUMPHREY FUNERAL HOME/ BETHESA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | acute pneumonitis | days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | congestive heart failure | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | advanced age | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D22780 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER M RICHISS MD 7500 Greenway Ctr Dr Greenbelt Md 20770 | | |
| 31. DATE FILED (Month, Day, Year): SEP 11 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 2603P

89 26035

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eric Ross Thorsell | | | 2. DATE OF DEATH: MONTH 9 DAY 9 YEAR 1989 | 3. TIME OF DEATH: 4:50 M |
| 4. SOCIAL SECURITY NUMBER: 578-32-9118 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-4-06 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 13503 Briarcroft Court | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Prince George |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Laurel | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 13503 Briarcroft Court | | 10f. ZIP CODE: 20708 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Safety Fire Specialist | 16b. KIND OF BUSINESS/INDUSTRY: Federal Aviation Administ. | |
| 17. FATHER'S NAME (First, Middle, Last): Jean A. Thorsell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amie Ross | |
| 19a. INFORMANT'S NAME (Type/Print): Jane T. West | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 536 Round Table Drive Ft. Washington MD 20744 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Balt. Washington Crematory | 20c. LOCATION — City or Town, State: Laurel, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Natalie Dulea Lee | | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | Hypertensive cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond P. Conjura MD | 29c. LICENSE NUMBER: D21230 | 29d. DATE SIGNED (Month, Day, Year): Sept 19 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raymond P. Conjura MD 5079 Raymond Ct Camp Spr. Md 20748 | | |
| 31. DATE FILED (Month, Day, Year): SEP 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

UTSEY, ROBERT

89 26036

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert Utsey | | 2. DATE OF DEATH (Month, Day, Year): 9 / 12 / 89 | 3. TIME OF DEATH: 6:45 AM |
| 4. SOCIAL SECURITY NUMBER: 578-16-2137A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (If yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/29/17 |
| 8. BIRTHPLACE (State or Foreign Country): S.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Clinton | 9c. COUNTY OF DEATH: Prince George's | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Clinton, | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3402 Delancey Street | 10f. ZIP CODE: 20735 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 8/30/43 - 11/7/46 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Dairy | |
| 17. FATHER'S NAME (First, Middle, Last): George Utsey | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Bowman | | |
| 19a. INFORMANT'S NAME (Type/Print): Augusta Utsey | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3402 Delancey St. Clinton, Md | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): To be Transferred To | 20c. LOCATION — City or Town, State: Orangeburg, S.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. O. Able | 22. NAME AND ADDRESS OF FACILITY: Hall Bros. Funeral Home 621 Fla. Ave., N.W. Wash., D.C. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBROVASCULAR ACCIDENT | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DIABETES MELLITUS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. S/P MULTIPLE CEREBRAL INFARCTS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RECENT URINARY TRACT INFECTION

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Terence Dahle MD | D 30041 | ▶ 9/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 14 '89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth P. VANTUYN
2. DATE OF DEATH: MONTH 8 DAY 25 YEAR 89
3. TIME OF DEATH: 5:55 A M
4. SOCIAL SECURITY NUMBER: 189-22-2375
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 09 07 15
8. BIRTHPLACE (State or Foreign Country): Penn.

RESIDENCE OF DECEDENT

9a. FACILITY NAME (If not institution, give street and number): Southern MARYland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON
9c. COUNTY OF DEATH: PRINCE Georges

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Clinton
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8600 Mike Shipiro Drive
10f. ZIP CODE: 20735
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): Nursing School
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse R.N.
16b. KIND OF BUSINESS/INDUSTRY: Nursing Medical

17. FATHER'S NAME (First, Middle, Last): George Hancock
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie J. Rittenhouse

19a. INFORMANT'S NAME (Type/Print): Beth Gateau
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 217 Teaques Point Rd Hughesville, Md 20637

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
20c. LOCATION — City or Town, State: Cheltenham, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOGENIC SHOCK

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

c. CORONARY ARTERY DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d. ATHEROSCLEROSIS / HYPERLIPIDEMIA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBESITY
PREVIOUS CORONARY BYPASS SURGERY

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Danilo B Lee MD DANILO LEE, MD
29c. LICENSE NUMBER: D15789
29d. DATE SIGNED (Month, Day, Year) ▶ 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANILO LEE MD 7700 OLD BRANCH AVENUE CLINTON, MD 20735

31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lydia Byers Verdelli
2. DATE OF DEATH: MONTH 8 DAY 25 YEAR 89
3. TIME OF DEATH: 5:10 P M
4. SOCIAL SECURITY NUMBER: 199-14-7943
5. SEX: 1 ☐ M 2 ☒ F XX
6. AGE (In yrs. last birthday): 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): April 6, 1899
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton, Md.
9c. COUNTY OF DEATH: Prince George Co.

RESIDENCE OF DECEDENT

10a. STATE: M.D.
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: Clinton
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9409 Piscataway Road
10f. ZIP CODE: 20735
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker/Real Estate
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): David Byers
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Kuntz
19a. INFORMANT'S NAME (Type/Print): Angela Allard
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9409 Piscataway Rd.,Clinton,Md.20735
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvery Cemetery
20c. LOCATION — City or Town, State: Cleveland Ohio
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old alexander Ferry Road Clinton,Maryland 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEVERE ATHEROSCLEROTIC CORONARY ARTERY DISEASE | Years. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CARDIAC ARRHYTHMIAS, | MONTHS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. intractable congestive heart failure. | months. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. ischemic strokes. with cerebral arterioasclerosis. | months. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~venous insufficiency of right lower leg with phlebitis~~, depression-senile, legal blindness, severe sensory neural hearingimpairment

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D12884
29d. DATE SIGNED (Month, Day, Year): AUG.26 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER W.YIM M.D. 7900 OLD BRANCH AVE.SUITE 101,CLINTON,MARYLAND 20735
31. DATE FILED (Month, Day, Year): SEP 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 26039

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Warr, Sr.
2. DATE OF DEATH (Month, Day, Year): 08 29 89
3. TIME OF DEATH: 2:40PM M
4. SOCIAL SECURITY NUMBER: 257-28-7353
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 07 10 24
8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Landover
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6706 West Forest Rd Apt 303
10f. ZIP CODE: 20785
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Guard Supervisor
16b. KIND OF BUSINESS/INDUSTRY: Fed. Govt.
17. FATHER'S NAME (First, Middle, Last): Roy Levi Warr
18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Jane Chapman
19a. INFORMANT'S NAME (Type/Print): Carrie A. Warr
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 A-F
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
20c. LOCATION — City or Town, State: Cheltenham, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark D. Lee
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End stage liver disease (alcoholic)

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hepatic encephalopathy.

DUE TO (OR AS A CONSEQUENCE OF):

c. Cirhosis & portal Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D35386
29d. DATE SIGNED (Month, Day, Year): 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JANET S. MARTIN, M.D. 6510 KENILWORTH Ave #2400 Riverdale, md. 20737

31. DATE FILED (Month, Day, Year): SEP 07 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

(B) (12) IVA

89 26040

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Laurence (N.M.I.) Williams | | | 2. DATE OF DEATH (Month, Day, Year) Sept. 6 1989 | 3. TIME OF DEATH 3:15 A M |
| 4. SOCIAL SECURITY NUMBER 506-10-8806 | 5. SEX 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday) 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 6-14-05 | 8. BIRTHPLACE (State or Foreign Country) Stratton, Nebraska |
| 9a. FACILITY NAME (If not institution, give street and number) Leland Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Riverdale MD | | 9c. COUNTY OF DEATH Prince Georges | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Maryland | 10b. COUNTY Prince George's | 10c. CITY, TOWN OR LOCATION Hyattsville | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER 4407 Tuckerman Street | 10f. ZIP CODE 20782 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Project Manager | 16b. KIND OF BUSINESS/INDUSTRY U.S. Government |
| 17. FATHER'S NAME (First, Middle, Last) Dwight Kincaid | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lavina Della Weller | |
| 19a. INFORMANT'S NAME (Type/Print) Audrey F. Williams (Wife) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4407 Tuckerman Street Hyattsville, Maryland 20782 | |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | 20c. LOCATION — City or Town, State Brentwood, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Robert M Bowen | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Prostate Cancer | 7yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ronald C. Kretkowski M.D. | D15273 | ▶ 9/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ronald C. Kretkowski, M.D. 4404 Queensbury Road, Riverdale, Maryland 20737

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 08 '89 | Julia Davidson-Randall |

(15)

DHMH-18 Rev 1/89

83 2601.0

89 26041

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

(6)

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ethel WAMSLEY | | | | | 2. DATE OF DEATH (Month / Day / Year): 08 / 29 / 89 | 3. TIME OF DEATH: 11:20 p M |
| 4. SOCIAL SECURITY NUMBER: 567-20-0895 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb 1 1896 | 8. BIRTHPLACE (State or Foreign Country): Minnesota |
| 9a. FACILITY NAME (If not institution, give street and number): AMI DRS' HOSPITAL OF PG COUNTY | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | | 9c. COUNTY OF DEATH: Prince Georges | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Mitchellville | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 3800 Lottsford Vista Rd. | | 10f. ZIP CODE: 20716 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Cauc. | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Rath | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Guyette | |
| 19a. INFORMANT'S NAME (Type/Print): Shirley A. Ashley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7849 Midday Lane Alexandria, Virginia 22306 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | | | 20c. LOCATION — City or Town, State: Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Will E Bowen Jr | | 22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebro Vascular Accident

DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Dehydration

DUE TO (OR AS A CONSEQUENCE OF): d. Pseudomembranous Colitis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D 14156

29d. DATE SIGNED (Month, Day, Year): ▶ 8.30.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ciro Montanez 3308 Dodge PK Rd Landover MD

31. DATE FILED (Month, Day, Year): 8.31.89 | SIGNATURE: Julia [illegible]

DHMH-16 Rev 1/89

89 26042

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELVA. B, WESLEY | | | 2. DATE OF DEATH (Month, Day, Year): SEPT. 3 1989 | 3. TIME OF DEATH: 0320 A M |
| 4. SOCIAL SECURITY NUMBER: 216-24-2967 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-17-09 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel/Beltsville Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Prince Georges |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Geo. | 10c. CITY, TOWN OR LOCATION: Laurel | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 702 Gorman Ave., Apt. 201 | | 10f. ZIP CODE: 20707 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): George Johnson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Mitchell | |
| 19a. INFORMANT'S NAME (Type/Print): George Gibson (nephew) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6411 Fairbanks St., New Carrollton, MD 20784 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. Nat'l Memorial Park | 20c. LOCATION — City or Town, State: Laurel, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden | 22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home, P.A. Rockville, MD 20850 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. congestive heart failure

d. Hypertrophic gastritis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: V. P. Chandar | 29c. LICENSE NUMBER: D16380 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. Prem Chandar, MD. | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 SEQ#2

89 26043

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Harold Eugene Wall | | | | 2. DATE OF DEATH (Month, Day, Year): August 27 | 3. TIME OF DEATH: 1135 M |
| 4. SOCIAL SECURITY NUMBER: 577-56-1533 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09 27 05 |
| 8. BIRTHPLACE (State or Foreign Country): Missouri | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 7920 Allentown Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Washington | | 9c. COUNTY OF DEATH: Prince George's |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Ft. Washington | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7920 Allentown Road | | 10f. ZIP CODE: 20744 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist | 16b. KIND OF BUSINESS/INDUSTRY: Dept. of Navy Fed. Govt. | |
| 17. FATHER'S NAME (First, Middle, Last): Samuel Wesley Wall | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida May Mitchell | |
| 19a. INFORMANT'S NAME (Type/Print): Doris May Priest | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5702 Spruce Drive Clinton, Md 20735 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd CLinton, Md20735 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD | 29c. LICENSE NUMBER: D21230 | 29d. DATE SIGNED (Month, Day, Year): August 27, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

89 26044

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen YORKSHIRE | | | 2. DATE OF DEATH (Month, Day, Year): September 2, 1989 | 3. TIME OF DEATH: 1:00P M |
| 4. SOCIAL SECURITY NUMBER: 577-32-2122 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 4, 1902 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | | 9c. COUNTY OF DEATH: Prince George's |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: District of Columbia | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Washington | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2640 Wade Road, S.E. | | 10f. ZIP CODE: 20020 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Private | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Skinner | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Butler | |
| 19a. INFORMANT'S NAME (Type/Print): Mary E. Hardy | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1827 S Street, S.E. Wash. D.C. | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery | 20c. LOCATION — City or Town, State: Arlington, VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John T. Stewart, III | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Road, N.E. Wash. D.C. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Subarachnoid hemorrhage | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ruptured Aneurysm | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congenital | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D21691 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.H. DEE M.D. P.A. 8830 Cameron St. St. 111 S.S.M.D. 20910 | | |
| 31. DATE FILED (Month, Day, Year): SEP 08 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-15 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

6

89 26045

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Carson K. Lawson | | 2. DATE OF DEATH (Month, Day, Year): Sept. 1, 1989 | 3. TIME OF DEATH: 11:00P M |
| 4. SOCIAL SECURITY NUMBER: 218-03-4362 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 17, 1912 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Johnsons Creek Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Crisfield, Md. | 9c. COUNTY OF DEATH: Somerset | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Somerset | 10c. CITY, TOWN OR LOCATION: Crisfield, Md. | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Johnsons Creek Road | 10f. ZIP CODE: 21817 | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman | 16b. KIND OF BUSINESS/INDUSTRY: Seafood | |
| 17. FATHER'S NAME (First, Middle, Last): Derrick K. Lawson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Jane Tyler | | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas P. Lawson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): East Ranier Drive, Parsonsburg, Md. 21849 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Asbury Cemetery | 20c. LOCATION — City or Town, State: Crisfield, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gregory C. Sterling Sr. | 22. NAME AND ADDRESS OF FACILITY: Sterling Funeral Home Crisfield, Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF): — Approximate Interval Between Onset and Death: Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): — Approximate Interval Between Onset and Death: Years

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M |
| 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Sterling, MD | 29c. LICENSE NUMBER: D10214 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): JAMES A. STERLING; 320 W. MAIN; CRISFIELD, MD. 21817

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP 05 89 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 26046

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GORDON BERNHARDT THORNE SR. | | | 2. DATE OF DEATH: MONTH 9 DAY 2 YEAR 89 | 3. TIME OF DEATH: 12:02 AM |
| 4. SOCIAL SECURITY NUMBER: 578-56-0665 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 44 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-7-1945 | 8. BIRTHPLACE (State or Foreign Country): Wash. D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 45 County Oak Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Mechanicsville | | 9c. COUNTY OF DEATH: St. Mary's |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: St. Mary's | 10c. CITY, TOWN OR LOCATION: Mechanicsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 49 County Oak Road | | 10f. ZIP CODE: 20659 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Firefighter | 16b. KIND OF BUSINESS/INDUSTRY: Public Protection | | |
| 17. FATHER'S NAME (First, Middle, Last): Norman Ellsworth Thorne, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Effie Gertrude Gordon Thorne | | |
| 19a. INFORMANT'S NAME (Type/Print): Carol Thorne | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 49 County Oak Road, Mechanicsville, Md. 20659 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Trinity Memorial Gardens | 20c. LOCATION — City or Town, State: Waldorf, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joan F. Huntt | | 22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Md. 20604 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Non Small Cell Carcinoma of Lung with metastasis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D19917

29d. DATE SIGNED (Month, Day, Year): ▶ 9/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Boyd M.D., Mechanicsville, Md.

31. DATE FILED (Month, Day, Year): SEP 06 '89

32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

89 26047

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Grace Beck Bradley
2. DATE OF DEATH — MONTH: 8 DAY: 31 YEAR: 89
3. TIME OF DEATH: 10 45 a M
4. SOCIAL SECURITY NUMBER: 288-40-6843
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-11-07
8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): 342 Perry Cabin Dr.
9b. CITY, TOWN OR LOCATION OF DEATH: St. Michaels
9c. COUNTY OF DEATH: Talbot Co.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Talbot
10c. CITY, TOWN OR LOCATION: St. Michaels
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 342 Perry Cabin Dr.
10f. ZIP CODE: 21663
10g. CITIZEN OF WHAT COUNTRY?: U. S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Educator
16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): George S. Beck
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Elizabeth Jackson
19a. INFORMANT'S NAME (Type/Print): Mary Ann Bradley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 342 Perry Cabin Dr. - St. Michaels MD 21663
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Crematory - Claridon (OH) Cemetery
20c. LOCATION — City or Town, State: Salisbury MD + Claridon OH
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Curran MO0125
22. NAME AND ADDRESS OF FACILITY: CURRAN FUNERAL HOME 308 HIGH ST., CAMBRIDGE, MD. 21613

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CANCER — 1 yr
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KEVIN J. O'KEEFE MD ROUTE 3 BOX 106 EASTON MD. 21601
31. DATE FILED (Month, Day, Year): SEP - 5 '89
32. REGISTRAR'S SIGNATURE: Davidson-Randall

DHMH-16 Rev 1/89

89 26047

89 26048

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John WESLEY Corkell

2. DATE OF DEATH: MONTH August DAY 24 YEAR 1989

3. TIME OF DEATH: 11:10 A.M.

4. SOCIAL SECURITY NUMBER: 217-36-0312

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 4-3-01

8. BIRTHPLACE (State or Foreign Country): DEL.

9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Easton

9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: CAROLINE

10c. CITY, TOWN OR LOCATION: RURAL DENTON

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER:

10f. ZIP CODE: 21629

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHT.

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): ✓ College (1-4 or 8 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMING

16b. KIND OF BUSINESS/INDUSTRY: AGRICULTURE

17. FATHER'S NAME (First, Middle, Last): JOHN WM. CORKELL

18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA VIRGINIA SMITH

19a. INFORMANT'S NAME (Type/Print): JUANITA LASHER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD DENTON MD 21629

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DENTON CEMETERY

20c. LOCATION — City or Town, State: DENTON, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Rudolph C Moore

22. NAME AND ADDRESS OF FACILITY: MOORE FUNERAL HOME, DENTON, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis — 24h.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pneumonia — 7D

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile P.U.D. & Insanitim

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert J. Melfi

29c. LICENSE NUMBER: D36411

29d. DATE SIGNED (Month, Day, Year): 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert J. Melfi 506 Idlewild Ave Easton, MD 21601

31. DATE FILED (Month, Day, Year): AUG 28 '89

32. REGISTRAR'S SIGNATURE: Kendall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 26049

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Shirley M. Bowersox | | | 2. DATE OF DEATH (Month, Day, Year): 9 6 89 | 3. TIME OF DEATH: 5:05 pM |
| 4. SOCIAL SECURITY NUMBER: 219-26-9920 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01 23 38 | 8. BIRTHPLACE (State or Foreign Country): Dist. of Col. |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | 9c. COUNTY OF DEATH: Talbot | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Talbot | 10c. CITY, TOWN OR LOCATION: Cordova | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Route 1, Box 849 | | 10f. ZIP CODE: 21625 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Walter C. Bowie | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Welsh | |
| 19a. INFORMANT'S NAME (Type/Print): George A. Bowersox | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1 Box 849 Cordova, MD 21625 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/9/89 | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Spring Hill Cemetery | 20c. LOCATION — City or Town, State: Easton, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John R. Mewson | | 22. NAME AND ADDRESS OF FACILITY: Newnam Funeral Home Easton, Maryland | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Coronary cardiac arrhythmias | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | acute myocardial infarction | ± 1 hr. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | coronary artery disease | yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | arteriosclerotic cardiovascular disease | yrs. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus, severe, insulin dependent

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Albert Dawkins MD | 29c. LICENSE NUMBER: MD 7872 | 29d. DATE SIGNED (Month, Day, Year): ▶ 7 Sept 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALBERT T. DAWKINS, JR., M.D. 508 IDLEWILD AVENUE EASTON, MARYLAND 21601

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): SEP - 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Register-Randall |

10

DHMH-16 Rev 1/89

89 2604

89 26050

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): GRACE Lipscomb CUNNINGHAM

**2. DATE OF DEATH** (Month, Day, Year): 8 20 89

**3. TIME OF DEATH**: 6:40PM

**4. SOCIAL SECURITY NUMBER**: 145-26-0409

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 94 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Feb. 19, 1895

**8. BIRTHPLACE** (State or Foreign Country): Missouri

**9a. FACILITY NAME** (If not institution, give street and number): Meridan - The Pines

**9b. CITY, TOWN OR LOCATION OF DEATH**: EASTON, Md

**9c. COUNTY OF DEATH**: TALBOT

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Talbot

**10c. CITY, TOWN OR LOCATION**: Trappe

**10d. INSIDE CITY LIMITS?** ☒ 1 YES 2 ☐ NO

**10e. STREET AND NUMBER**: 130 South Main Street

**10f. ZIP CODE**: 21673

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Housewife

**16b. KIND OF BUSINESS/INDUSTRY**: Home

**17. FATHER'S NAME** (First, Middle, Last): William Stapleton Lipscomb

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Jimmy Andrews

**19a. INFORMANT'S NAME** (Type/Print): Doris C. Brooks

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): Santa Rosa, Ca. 1630 Terrace Way 95404

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Woodbine Cemetery

**20c. LOCATION — City or Town, State**: Harrisonburg, Va.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Ronald W. Filbaby

**22. NAME AND ADDRESS OF FACILITY**: Williamson Funeral Home, 311 S. Main St. Federalsburg, Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. gangrene of foot
DUE TO (OR AS A CONSEQUENCE OF):
b. peripheral vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. arteriosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

hypertension
senile dementia
intermittent bowel obstruction

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**28. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: R.B. Sanchez MD

**29c. LICENSE NUMBER**: D25750

**29d. DATE SIGNED** (Month, Day, Year) ▶ 8/21/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): 508 Idaville Easton MD 2160- R.B. Sanchez

**31. DATE FILED** (Month, Day, Year): AUG 29 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 26051
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 1 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| LORNA EGEBERG | SEPT. 1 1989 | 5:45 P.M. |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-16-6264 | 1 ☐ M 2 ☒ F | 86 YRS. | | | 9-11-02 | Virginia |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Wm. HILL MANOR HEALTH CENTER | EASTON | TALBOT |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | TALBOT | EASTON | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 501 DUTCHMAN'S LANE | 21601 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Homemaker | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William Furlong | Hattie Minor |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Joseph D. Egeberg, Jr. | 3580 S. Ocean Shore Blvd. Flagler Bch. Fla 32136 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Glen Haven Cemetery | Glen Burnie, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ J. A. Barranco | 495 Ritchie Highway Barranco Funeral Home Severna Park, MD 21146 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease
Organic Brain Syndrome
Osteoarthritis

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ ND | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Gary J. Sprouse MD | D32036 | ▶ 9/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gary J. Sprouse P.O. Box 210 Queenstown MD 21658

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| SEP 06 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

17

89 26051

89 26052

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been Signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elzora Ellis | | | 2. DATE OF DEATH (Month, Day, Year): 8 28 89 | 3. TIME OF DEATH: 1:50 A M |
| 4. SOCIAL SECURITY NUMBER: 217-12-4645-A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9-5-1898 | 8. BIRTHPLACE (State or Foreign Country): Alabama |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | 9c. COUNTY OF DEATH: Talbot | | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: M.D. | 10b. COUNTY: Talbort | 10c. CITY, TOWN OR LOCATION: Preston Maryland | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: Rt 1 Box 38 A-1 Preston | 10f. ZIP CODE: | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Blk | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domostic | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Rev William Stringer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Stringer | | | |
| 19a. INFORMANT'S NAME (Type/Print): Charlie Blue | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. Box 38 A-1 Preston M.D. | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Johns Cemetery | 20c. LOCATION — City or Town, State: Preston M.D. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell Fooks | 22. NAME AND ADDRESS OF FACILITY: Fooks Funeral Home P.O.B. 1574 Salisbury M.D. | | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Heart Dis- | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P Gregg Rhodes MD. 503 Datchmans La, Easton, Md 21601

31. DATE FILED (Month, Day, Year): SEP 5 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rhodes

DHMH-16 Rev 1/89

89 26053

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY GARDNER | | | 2. DATE OF DEATH (Month / Day / Year): 8 / 19 / 89 | 3. TIME OF DEATH: 4:16 AM |
| 4. SOCIAL SECURITY NUMBER: 220-03-9490 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4/13/08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): EASTON MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: EASTON | | 9c. COUNTY OF DEATH: TALBOT |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Greensboro | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 1 Box 336 | | 10f. ZIP CODE: 21639 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse | 16b. KIND OF BUSINESS/INDUSTRY: Health Care | |
| 17. FATHER'S NAME (First, Middle, Last): Alfred Bramble. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Reynolds | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. John Richard Gardner, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 336, Greensboro, MD 21639 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery | 20c. LOCATION — City or Town, State: Greensboro, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Fleegle Fleegle | | 22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home P.O. Box 160, Greensboro, MD 21639 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Myocardial Infarction | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Coronary artery disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY — M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Monica Lynn Agree MD | 29c. LICENSE NUMBER: D35127 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Monica Agree MD | | Denton, MD 21629 |
| 31. DATE FILED (Month, Day, Year): AUG 25 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

89 26054

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Horace Emerson Hambleton | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 1 1989 | 3. TIME OF DEATH: 7:00A.M. M |
| 4. SOCIAL SECURITY NUMBER: 217-30-8623 A | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 4, 1919 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Cooper Point Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bozman | | 9c. COUNTY OF DEATH: Talbot |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Talbot | 10c. CITY, TOWN OR LOCATION: Bozman | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: Cooper Point Road | | 10f. ZIP CODE: 21612 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+): | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman | 18b. KIND OF BUSINESS/INDUSTRY: Seafood | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas B. Hambleton | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian O. Burrows | |
| 19a. INFORMANT'S NAME (Type/Print): Lois Reed Hambleton | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cooper Pt. Rd. Bozman, Maryland 21612 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bozman Methodist Cemetery | 20c. LOCATION — City or Town, State: Bozman, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harrison E. Leonard | | 22. NAME AND ADDRESS OF FACILITY: Harrison E. Leonard Funeral Home 21663, 312 S. Talbot St. St. Michaels, Maryland | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Exsanguination 2° to Carotid artery hemorrhage | Minutes |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Metastatic Carcinoma of Larynx | 2yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA — OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Wm Wood MD | 29c. LICENSE NUMBER: D08715 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WMH Wood Jr MD EASTON, Md 21601 | | |
| 31. DATE FILED (Month, Day, Year): SEP - 6 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 26055

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joseph Harrington | | | 2. DATE OF DEATH (Month, Day, Year): 8 22 89 | 3. TIME OF DEATH: 8:37 PM |
| 4. SOCIAL SECURITY NUMBER: 214-03-4662 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11 14 1907 | 8. BIRTHPLACE (State or Foreign Country): Delaware |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | | 9c. COUNTY OF DEATH: Talbot |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Denton | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 424 South Second Street | 10f. ZIP CODE: 21629 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th gr. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Food Industry | |
| 17. FATHER'S NAME (First, Middle, Last): John Smithers Harrington | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanor Ennis | |
| 19a. INFORMANT'S NAME (Type/Print): Esther B. Harrington | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 424 South Second Street, Denton, MD 21629 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Denton Cemetery | 20c. LOCATION — City or Town, State: Denton, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph P. Moore | | 22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Denton, Maryland 21629 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Bleeding from stress ulcer | 2 wks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | STROKE + SIEZURE | 19 dy |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: LUNG CANCER

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D-01227 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): AUG 25 '89 | 32. REGISTRAR'S SIGNATURE: Tina Davidson-Randall | |

DHMH-16 Rev 1/89

89 26056

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Patrick | | | 2. DATE OF DEATH: MONTH 9 DAY 6 YEAR 89 | 3. TIME OF DEATH: 4:06 p M |
| 4. SOCIAL SECURITY NUMBER: 204-18-7908 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12 12 25 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | 9c. COUNTY OF DEATH: Talbot | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Talbot | 10c. CITY, TOWN OR LOCATION: Easton | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 208 Brookletts Avenue | | 10f. ZIP CODE: 21601 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): route salesman | 16b. KIND OF BUSINESS/INDUSTRY: beverage | | |
| 17. FATHER'S NAME (First, Middle, Last): William Patrick | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna (unknown) | | |
| 19a. INFORMANT'S NAME (Type/Print): Phyllis W. Patrick | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 Brookletts Avenue, Easton, MD 21601 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) 9/9/89 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Spring Hill Cemetery | 20c. LOCATION — City or Town, State: Easton, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John R. Newnam | 22. NAME AND ADDRESS OF FACILITY: Newnam Funeral Home, Easton, Maryland | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. intracerebral hemorrhage | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. chronic hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

prostatic stricture disease chronic
Pul. Sh. Vasc. Disease Coumadin
metastatic prostate cancer therapy

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D25750 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-7-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.J. SANCHEZ 500 Idlewild Ave Easton MD 21601 | | |
| 31. DATE FILED (Month, Day, Year): SEP - 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 26057

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward Pitts | | | 2. DATE OF DEATH (Month, Day, Year): 8 23 89 | 3. TIME OF DEATH: 7:42 pm |
| 4. SOCIAL SECURITY NUMBER: 229-38-9587 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-18-34 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | | 9c. COUNTY OF DEATH: Talbot |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Talbot | 10c. CITY, TOWN OR LOCATION: Easton | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 215 Adkins Ave. | | 10f. ZIP CODE: 21601 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Elementary; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction | 16b. KIND OF BUSINESS/INDUSTRY: Builing | |
| 17. FATHER'S NAME (First, Middle, Last): Littleton Pitts | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Parher | |
| 19a. INFORMANT'S NAME (Type/Print): Emma Pitts | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 215 Adkins Ave. Easton, Md. 21601 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wharton Cem. | 20c. LOCATION — City or Town, State: Parksley, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith E. S. Wharton | | 22. NAME AND ADDRESS OF FACILITY: Wharton Funeral Home-Accomac, Va | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrest | 2H |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Prob Massive Myocardial Infarction | Hours |
| DUE TO (OR AS A CONSEQUENCE OF): c. | ASCVD | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Transplant
Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: D. Lewis MD

29c. LICENSE NUMBER: D05874

29d. DATE SIGNED (Month, Day, Year): 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. LEWIS Memorial Hosp. Easton, MD.

31. DATE FILED (Month, Day, Year): AUG 28 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

5

DHMH-16 Rev 1/89

89 26058

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Larry D. Pendry | | 2. DATE OF DEATH (Month, Day, Year): 8-22-89 | 3. TIME OF DEATH: 11:57PM M |
| 4. SOCIAL SECURITY NUMBER: 234-58-7560 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-20-1940 |
| 8. BIRTHPLACE (State or Foreign Country): Sophia, W.Va. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL AT EASTON | 9b. CITY, TOWN OR LOCATION OF DEATH: EASTON | 9c. COUNTY OF DEATH: Talbot County | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: Del. | 10b. COUNTY: Kent | 10c. CITY, TOWN OR LOCATION: Felton, Rd.2 Box 899 | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Rd 2 Box 899 | 10f. ZIP CODE: 19943 | 10g. CITIZEN OF WHAT COUNTRY? U S | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Navy 1959-1963 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Herbert Pendry | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Pendry | | |
| 19a. INFORMANT'S NAME (Type/Print): Father-Herbert Pendry | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd 2 Box 899 Felton, Del. 19943 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olive | 20c. LOCATION — City or Town, State: Sandtown, Del. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ross W. Trader | 22. NAME AND ADDRESS OF FACILITY: Trader Funeral Home Inc. 12 Lotus St., Dover, Del. 19901 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wounds (2) of right arm and abdomen

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient XX ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide XXX 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8-22-89 | 28b. TIME OF INJURY: 10:44PM |
| 28c. INJURY AT WORK? 1 [ ] YES XX [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOUSE | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 1, Box 117, Henderson, Caroline County, Maryland | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 8-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): SEP 25 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 26059

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit-permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT G SPRING | | | 2. DATE OF DEATH (Month, Day, Year): 8 20 89 | 3. TIME OF DEATH: 6:40A M |
| 4. SOCIAL SECURITY NUMBER: 215-12-9901 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6 9 1918 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Easton | | 9c. COUNTY OF DEATH: Talbot |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Harmony | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ ND |
| 10e. STREET AND NUMBER: Todd's Wharf Lane | | 10f. ZIP CODE: 21655 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H.S.Grad. College (1-4 or 5+): College Gr. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer Chief Electronics | | 16b. KIND OF BUSINESS/INDUSTRY: Food Instruments |
| 17. FATHER'S NAME (First, Middle, Last): Dr. Gardner Spring | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Ruark | | |
| 19a. INFORMANT'S NAME (Type/Print): Ellwood Luber | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4630 Poole Road, Eldersburg, MD 21784 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern Shore Crematory | | 20c. LOCATION — City or Town, State: Georgetown, Del. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles V. Moore | | 22. NAME AND ADDRESS OF FACILITY: Moore Fun. Home Denton Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Extensive Brain Damage | 24-48° |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypotension | 24-48° |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congestive Heart Failure. | 5 Days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. ASCVD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| N/A | M | 1 ☐ YES 2 ☐ NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robert J. Melfi MD | D36411 | 8/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert J. Melfi MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| AUG 23 '89 | Gloria Davidson-Randall |

DHMH-16 Rev 1/89

89 26029

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 26060

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GLADYS E. MARTIN (GLADYS E. MARTIN)
2. DATE OF DEATH: MONTH SEPT DAY 4 YEAR 1989
3. TIME OF DEATH: 11:13 A M
4. SOCIAL SECURITY NUMBER: 572 44 8837
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan 17 1899
8. BIRTHPLACE (State or Foreign Country): Canada
9a. FACILITY NAME (If not institution, give street and number): Williamsport Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Williamsport
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Takoma Park
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO XX
10e. STREET AND NUMBER: 7051 Carroll Avenue
10f. ZIP CODE: 20783
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married XX 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XX — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X — Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): Yes
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Voice & English Teacher
16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Joseph Capman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Russell
19a. INFORMANT'S NAME (Type/Print): Patricia M. Hare
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3001 Veazey Ter. N.W., Washington DC 20008
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery
20c. LOCATION — City or Town, State: Adelphi, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: OSBORNE FUNERAL HOMES P.O.Box # 348 Williamsport,MD21795

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GENITOURINARY SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMERS DEMENTIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: T E Howe MD
29c. LICENSE NUMBER: D33700
29d. DATE SIGNED (Month, Day, Year) ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TED E. HOWE OLNEY, MARYLAND
31. DATE FILED (Month, Day, Year): SEP 6'89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 26060

89 26061

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mable L. Adams | | | 2. DATE OF DEATH (Month, Day, Year): August 15 1989 | 3. TIME OF DEATH: 0550 ☐ A ☑ M |
| 4. SOCIAL SECURITY NUMBER: 230-48-1509 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 50 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 9, 1938 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY | | 9c. COUNTY OF DEATH: WICOMICO |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Virginia | 10b. COUNTY: Accomack | 10c. CITY, TOWN OR LOCATION: Chincoteague | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Ridge Road | 10f. ZIP CODE: 23336 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Grocery Store | |
| 17. FATHER'S NAME (First, Middle, Last): Francis Truitt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Thornton | |
| 19a. INFORMANT'S NAME (Type/Print): Brian Adams | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Ridge Road, Chincoteague, Virginia 23336 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): First Baptist Cemetery | 20c. LOCATION — City or Town, State: Pocomoke, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leon S. Salyer | 22. NAME AND ADDRESS OF FACILITY: Salyer Funeral Home, Chincoteague, Virginia 23336 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma of Colon | 1½ years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. E. Martin, M.D. | 29c. LICENSE NUMBER: 030690 | 29d. DATE SIGNED (Month, Day, Year): ▶ 8/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James E. Martin, M.D. 145 E. Carroll St., Salisbury, MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): AUG 22 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 26061

89 26062

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANCES L. ASHTON | | | 2. DATE OF DEATH — MONTH: 9 DAY: 6 YEAR: 89 | 3. TIME OF DEATH: 0031 AM |
| 4. SOCIAL SECURITY NUMBER: 556-70-8953 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3- 8- 1913 | 8. BIRTHPLACE (State or Foreign Country): IOWA |
| 9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury | | 9c. COUNTY OF DEATH: Wicomico |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: WORCESTER | 10c. CITY, TOWN OR LOCATION: BERLIN | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: RT 4 BOX 480 | | 10f. ZIP CODE: 21811 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): ----- College (1-4 or 5+): ----- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): GEORGE L. LaTOURETTE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE ---- PRATT | |
| 19a. INFORMANT'S NAME (Type/Print): TIMOTHY A. ASHTON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT 4 BOX 480, BERLIN, M D 21811 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SALISBURY CREMATORY | 20c. LOCATION — City or Town, State: SALISBURY, MD 21801 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Richard Holloway | | 22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
LUMBAR STENOSIS

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ronald P. Tuma MD | 29c. LICENSE NUMBER: D36576 | 29d. DATE SIGNED (Month, Day, Year): 9/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 560 RIVERSIDE DRIVE SALISBURY MD 21801 | | |
| 31. DATE FILED (Month, Day, Year): SEP 8 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Rydell | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 26062

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 26063 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 131..., BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Otis J. Beckett
2. DATE OF DEATH: MONTH 8 DAY 31 YEAR 89
3. TIME OF DEATH: 12 55 P M
4. SOCIAL SECURITY NUMBER: 213-22-7487
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-17-05
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): River Walk Manor
9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury
9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Worcester
10c. CITY, TOWN OR LOCATION: Pocomoke City
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 3 Bx. 53
10f. ZIP CODE: 21851
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Elem. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Farm
17. FATHER'S NAME (First, Middle, Last): John P. Beckett
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucinda Bishop
19a. INFORMANT'S NAME (Type/Print): Ernest Beckett
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Pocomoke City, Md. 21851
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Georgetown Cem.
20c. LOCATION — City or Town, State: Pocomoke City, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Samuel H. Savage
22. NAME AND ADDRESS OF FACILITY: P.O.Bx. 46 New Church, Va. 23415

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Arteriosclerosis c Infarction — years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Carcinoma of Larynx

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas C Hill M.D. Medical Director
29c. LICENSE NUMBER: D 08008
29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS C. HILL JR, 108 Pine Bluff Rd. Salisbury, Md 21801
31. DATE FILED (Month, Day, Year): SEP 5 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson Registrar

3

OHMH-15 Rev 1/89

89 26064

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Georgia M. Bailey
2. DATE OF DEATH (Month, Day, Year): Sept. 1, 1989
3. TIME OF DEATH: 3:00 A M
4. SOCIAL SECURITY NUMBER: 094-09-2136
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): MAY 23, 1903
8. BIRTHPLACE (State or Foreign Country): Naticoke, MD.
9a. FACILITY NAME (If not institution, give street and number): Deer's Head Center
9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury
9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: WICOMICO
10c. CITY, TOWN OR LOCATION: NANTICOKE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P.O. BOX 112, EAST NUTTER RD.
10f. ZIP CODE: 21840
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: AFRO-AMERICAN
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th, ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC
16b. KIND OF BUSINESS/INDUSTRY: HOUSEKEEPER
17. FATHER'S NAME (First, Middle, Last): LEONARD NUTTER
18. MOTHER'S NAME (First, Middle, Maiden Surname): SUSAN WHITE
19a. INFORMANT'S NAME (Type/Print): NANCY WORRELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other facility): ASHBURY UNITED M.C.
20c. LOCATION — City or Town, State: NANTICOKE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Loretta B. Jolley
22. NAME AND ADDRESS OF FACILITY: JOLLEY MEMORIAL CHAPEL RTE. 2, BOX 920, SALISBURY, MD. 21801

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the moda of dying, such ee cardiac or respiratory srrest, shock, or heart failure. List only one ceusa on aach lina. — Approximate Interval Between Onset and Dasth

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF
DUE TO (OR AS A CONSEQUENCE OF):
Sequantially list conditions, if eny, leading to immedieta ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. A S C V D
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Othar significant conditions contributing to death but not resulting in tha underlying cauea given in Part I.

Decubitus ulcer. Left Trochanter and left knee
Peripheral vascular disease
Chronic Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Shrestha MD
29c. LICENSE NUMBER: D16278
29d. DATE SIGNED (Month, Day, Year): 9.1.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maheswari Shrestha M.D. Deer's Head Center Salisbury, Md. 21801
31. DATE FILED (Month, Day, Year): SEP 5 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

5

DHMH-16 Rev 1/89

89 26065

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward Sidney Bevens | | | 2. DATE OF DEATH (Month / Day / Year): 9 / 2 / 89 | 3. TIME OF DEATH: 12:35 PM |
| 4. SOCIAL SECURITY NUMBER: 214-32-5101 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-15-32 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Rt.-2 Box 127 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Pocomoke | | 9c. COUNTY OF DEATH: Worcester |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Worcester | 10c. CITY, TOWN OR LOCATION: Pocomoke | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Rt.-2 Box 127 | | 10f. ZIP CODE: 21851 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: War II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): High Sch. 11 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fire Prot Tech | 16b. KIND OF BUSINESS/INDUSTRY: Fire Inspector | |
| 17. FATHER'S NAME (First, Middle, Last): Era Bevens | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Cottman | |
| 19a. INFORMANT'S NAME (Type/Print): Beatrice Ward | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1918 Colonial St. Phila.,Pa. 19138 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Tinsley Memorial | 20c. LOCATION — City or Town, State: Pocomoke, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Keith E. S. Wharton | 22. NAME AND ADDRESS OF FACILITY: Wharton Funeral Home-Accomac, Va. | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARCINOMA OF THE LUNG. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. G. Santiago M.D. PERSONAL PHYSICIAN | 29c. LICENSE NUMBER: D02556 | 29d. DATE SIGNED (Month, Day, Year): ▶ 9/7/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. G. SANTIAGO MD 100 8th ST. Pocomoke City MD 21851 | | |
| 31. DATE FILED (Month, Day, Year): SEP 07 '89 | 32. REGISTRAR'S SIGNATURE: SEP 07 '89 Julia Davidson-Randall | |

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 26066

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSALIE S. BENNETT | | | | 2. DATE OF DEATH: MONTH 8 DAY 30 YEAR 89 | 3. TIME OF DEATH: 2:25 A M |
| 4. SOCIAL SECURITY NUMBER: 216-40-3795 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | | 7. DATE OF BIRTH (Month, Day, Year): June 17, 1906 | 8. BIRTHPLACE (State or Foreign Country): Williamsport Md. |
| 9a. FACILITY NAME (If not institution, give street and number): SALISBURY NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MD. | | 9c. COUNTY OF DEATH: WICOMICO | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Wicomico | 10c. CITY, TOWN OR LOCATION: Salisbury | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: South Park Drive | | 10f. ZIP CODE: 21801 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Public School |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Charles Jesse Smith | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Beulah Pollitt |
| 19a. INFORMANT'S NAME (Type/Print): Susan B. Steele | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5846 Ross Neck Rd., Cambridge, Md. 21613 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parsons Cemetery | 20c. LOCATION — City or Town, State: Salisbury, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gerald C Bruner | 22. NAME AND ADDRESS OF FACILITY: 705 East Main St. , Salisbury, Md. 21801 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Coronary artery disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Multiple cerebral infarcts | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Senile Dementia | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William H Robins | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 8/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM ROBINS, M.D., RT. 50 & CIVIC AVE., SALISBURY, MD. 21801

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): AUG 31 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

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DHMH-16 Rev 1/89

89 26066

89 26067

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARTIN L. Black | | | 2. DATE OF DEATH (Month, Day, Year): September 1 1989 | 3. TIME OF DEATH: 1600 M |
| 4. SOCIAL SECURITY NUMBER: 222-07-8773 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6-3-1913 | 8. BIRTHPLACE (State or Foreign Country): Delaware |
| 9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury | | 9c. COUNTY OF DEATH: Wicomico |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Del. | 10b. COUNTY: Sussex | 10c. CITY, TOWN OR LOCATION: Milton | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 325 Union St. | | 10f. ZIP CODE: 19968 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Broker | 16b. KIND OF BUSINESS/INDUSTRY: Insurance |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Joseph Levin Black | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amanda Johnson |
| 19a. INFORMANT'S NAME (Type/Print): Jane L. Black | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 325 Union St., Milton, Del. 19968 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Crematory | 20c. LOCATION — City or Town, State: Salisbury, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gerald C Bounds | 22. NAME AND ADDRESS OF FACILITY: 705 E. Main St. Bounds Funeral Home, Salisbury, Md. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. WIDESPREAD METASTATIC CARCINOMA | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CARCINOMA of the PROSTATE | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia D. Zant MD | 29c. LICENSE NUMBER: D 19432 | 29d. DATE SIGNED (Month, Day, Year): 9/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia D. Zant 560 Riverside Dr Salisbury, Md. | | |
| 31. DATE FILED (Month, Day, Year): SEP 5 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 26067

89 26068

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George W. CONDON | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 3, 1989 | 3. TIME OF DEATH: 7:30 P M |
| 4. SOCIAL SECURITY NUMBER: 216-12-1558A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03/17/1912 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Deer's Head Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury | | 9c. COUNTY OF DEATH: Wicomico |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Dorchester | 10c. CITY, TOWN OR LOCATION: Cambridge | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Route #3 | | 10f. ZIP CODE: 21613 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

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|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White/Cauc. |

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|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): waterman | 16b. KIND OF BUSINESS/INDUSTRY: shellfish | |
| 17. FATHER'S NAME (First, Middle, Last): John Harry Condon | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Marshall | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Condon (son) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3, Box 952, Cambridge, MD. 21613 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Spedden-Seward Cemetery | 20c. LOCATION — City or Town, State: Cambridge, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Helen Curran-Bonwell mod718 | | 22. NAME AND ADDRESS OF FACILITY: Curran Funeral Home 308 High St., Cambridge, MD. 21613 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pemphigus | |
| | DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. ASHD, Chronic CHF | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Constante J. Tan M.D. | 29c. LICENSE NUMBER: MD 16725 | 29d. DATE SIGNED (Month, Day, Year): 9/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Constante J. Tan, M.D. 547-D Riverside Dr.; Salisbury, Md. 21801 | | |
| 31. DATE FILED (Month, Day, Year): SEP - 5 '89 | 32. REGISTRAR'S SIGNATURE: Jacqueline Randall | |

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